INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,278,041.87	ADJUSTMENTS	15,234.83
COVERED CHARGES	1,267,880.44	CONTRACTUAL ALLOW	496,828.44
NON-COVERED CHARGES	10,161.43	TOTAL MEDICAID LIAB	771,052.00
		LESS: COB	6,805.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	764,246.69

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	505	0	189,375.00	4,400.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	505	0	189,375.00	4,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	98	0	86,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	98	0	86,200.00	0.00
TOTAL ACCOMODATIONS	603	0	275,575.00	4,400.00

INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286,866.98	0.00
MED/SURG SUPPLY	176,758.95	0.00
LABORATORY-GENERAL	84,750.17	2,184.20
RADIOLOGY-DIAGNOSTIC	24,145.20	0.00
CT SCAN	27,170.40	0.00
PHYSICAL THERAPY	9,524.40	0.00
EKG/ECG	6,593.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	41,165.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	61,038.00	0.00
ANESTHESIA	2,322.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	160,924.88	0.00
RECOVERY ROOM	8,408.80	0.00
LABORATORY PATHOLOGIC	63.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,371.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,787.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,678.70	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,800.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	638.00	5.00
OTHER LAB SERVICES	3,846.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,203.68	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	32.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	73,248.28	3,539.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	992,305.44	5,761.43
TOTAL ACCOMODATIONS	275,575.00	4,400.00
TOTAL CHARGES	1,267,880.44	10,161.43

ZERO PAID INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	51,963.95	ADJUSTMENTS	0.00
COVERED CHARGES	51,660.95	CONTRACTUAL ALLOW	45,337.20
NON-COVERED CHARGES	303.00	TOTAL MEDICAID LIAB	6,323.75
		LESS: COB	6,323.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	32	0	12,000.00	250.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	32	0	12,000.00	250.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	32	0	12,000.00	250.00

ZERO PAID INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,240.52	0.00
MED/SURG SUPPLY	6,979.20	0.00
LABORATORY-GENERAL	1,995.70	53.00
RADIOLOGY-DIAGNOSTIC	957.70	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,100.10	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,309.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	338.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	856.63	0.00
RECOVERY ROOM	883.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	39,660.95	53.00
TOTAL ACCOMODATIONS	12,000.00	250.00
TOTAL CHARGES	51,660.95	303.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,419,490.54	ADJUSTMENTS	19,176.76
COVERED CHARGES	3,153,937.06	CONTRACTUAL ALLOW	1,767,132.49
NON-COVERED CHARGES	265,553.48	TOTAL MEDICAID LIAB	1,386,804.57
		LESS: COB	879.56
		LESS: COPAYMENT	4,713.00
		REIMBURSEMENT	1,381,212.01
		ALL OTHER	1,320,386.43
		FEE SCHEDULE-LAB	60,825.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4,726

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	238,837.22	18,180.52
MED/SURG SUPPLY	305,537.60	755.76
LABORATORY-GENERAL	31.00	12,744.10
RADIOLOGY-DIAGNOSTIC	151,153.68	16,509.60
CT SCAN	195,825.20	4,837.00
PHYSICAL THERAPY	0.00	2,362.30
EKG/ECG	26,775.30	350.00
IV THERAPY	0.00	0.00
OPERATING ROOM	144,676.31	42,476.49
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,896.10	116.00
ANESTHESIA	7,767.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,422,464.56	129,898.71
RECOVERY ROOM	44,816.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	403.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	117,130.20	1,621.60
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	335.10
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,947.60	740.60
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	74,100.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	130,965.76	5,226.90
OTHER LAB SERVICES	6,714.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	213,713.92	29,243.02
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	29,180.71	79.58
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	76.20

TOTAL ANCILLARY	3,153,937.06	265,553.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,153,937.06	265,553.48

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	72,903.00	ADJUSTMENTS	0.00
COVERED CHARGES	67,729.06	CONTRACTUAL ALLOW	20,273.96
NON-COVERED CHARGES	5,173.94	TOTAL MEDICAID LIAB	47,455.10
		LESS: COB	47,413.10
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,331.48-
		FEE SCHEDULE-LAB	1,331.48
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,207.44	561.59
MED/SURG SUPPLY	6,884.50	216.70
LABORATORY-GENERAL	0.00	458.70
RADIOLOGY-DIAGNOSTIC	3,053.70	508.50
CT SCAN	2,777.40	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	451.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,144.10	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,018.10	73.60
ANESTHESIA	555.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,253.77	2,028.76
RECOVERY ROOM	1,231.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,961.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	667.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,059.65	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,068.95	1,252.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	32.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	395.45	40.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,729.06	5,173.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,729.06	5,173.94

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	69,409.65	ADJUSTMENTS	194.90
COVERED CHARGES	67,340.65	CONTRACTUAL ALLOW	55,172.72
NON-COVERED CHARGES	2,069.00	TOTAL MEDICAID LIAB	12,167.93
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	11,894.93

TOTAL NUMBER OF CLAIMS 275

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,552.45	0.00
MED/SURG SUPPLY	3,652.50	0.00
LABORATORY-GENERAL	3,038.50	555.20
RADIOLOGY-DIAGNOSTIC	1,753.80	461.90
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	225.90	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	144.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,002.78	1,051.90
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	970.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,340.65	2,069.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,340.65	2,069.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,142.95	ADJUSTMENTS	0.00
COVERED CHARGES	4,028.05	CONTRACTUAL ALLOW	1,843.69
NON-COVERED CHARGES	114.90	TOTAL MEDICAID LIAB	2,184.36
		LESS: COB	2,172.36
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	236.13	0.00
MED/SURG SUPPLY	84.20	0.00
LABORATORY-GENERAL	312.40	114.90
RADIOLOGY-DIAGNOSTIC	324.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,036.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34.02	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,028.05	114.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,028.05	114.90

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW

THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	10,525.16	ADJUSTMENTS	0.00
COVERED CHARGES	9,826.99	CONTRACTUAL ALLOW	5,713.54
NON-COVERED CHARGES	698.17	TOTAL MEDICAID LIAB	4,113.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,113.45

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,202.25	189.27
MED/SURG SUPPLY	4,377.54	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	207.40	248.60
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	145.80
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,374.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	274.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	347.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,043.50	114.50
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,826.99	698.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,826.99	698.17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,846.59	ADJUSTMENTS	0.00
COVERED CHARGES	13,664.19	CONTRACTUAL ALLOW	3,581.43
NON-COVERED CHARGES	182.40	TOTAL MEDICAID LIAB	10,082.76
		LESS: COB	10,082.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,314.39	36.60
MED/SURG SUPPLY	8,163.30	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	145.80
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,218.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	65.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	347.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	555.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,664.19	182.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,664.19	182.40

INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,344,728.98	ADJUSTMENTS	0.00
COVERED CHARGES	1,327,481.88	CONTRACTUAL ALLOW	496,726.76
NON-COVERED CHARGES	17,247.10	TOTAL MEDICAID LIAB	830,755.12
		LESS: COB	9,056.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	821,698.41

TOTAL NUMBER OF ADMISSIONS 146

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	471	0	179,565.00	13,923.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	471	0	179,565.00	13,923.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	105	0	101,709.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	105	0	101,709.00	0.00
TOTAL ACCOMODATIONS	576	0	281,274.00	13,923.00

INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234,192.86	0.00
MED/SURG SUPPLY	186,410.65	0.00
LABORATORY-GENERAL	75,300.14	1,815.50
RADIOLOGY-DIAGNOSTIC	29,352.95	0.00
CT SCAN	18,139.00	0.00
PHYSICAL THERAPY	7,024.70	0.00
EKG/ECG	6,834.70	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	39,383.70	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	128,925.40	0.00
ANESTHESIA	10,860.48	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	184,131.30	0.00
RECOVERY ROOM	6,371.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,737.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,532.70	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,327.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	760.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,040.50	738.60
OTHER LAB SERVICES	526.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,680.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	770.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	91,674.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,046,207.88	3,324.10
TOTAL ACCOMODATIONS	281,274.00	13,923.00
TOTAL CHARGES	1,327,481.88	17,247.10

ZERO PAID INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,749,414.50	ADJUSTMENTS	121,338.92
COVERED CHARGES	3,506,578.67	CONTRACTUAL ALLOW	2,178,411.45
NON-COVERED CHARGES	242,835.83	TOTAL MEDICAID LIAB	1,328,167.22
		LESS: COB	1,282.21
		LESS: COPAYMENT	2,403.00
		REIMBURSEMENT	1,324,482.01
		ALL OTHER	1,266,646.13
		FEE SCHEDULE-LAB	54,786.58
		INJECTABLE DRUGS	3,049.30

TOTAL NUMBER OF CLAIMS 4,669

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,867.27	115,247.55
MED/SURG SUPPLY	345,594.31	21,073.38
LABORATORY-GENERAL	629.80	7,229.05
RADIOLOGY-DIAGNOSTIC	158,381.75	3,222.20
CT SCAN	227,968.60	0.00
PHYSICAL THERAPY	605.60	1,103.80
EKG/ECG	31,701.90	296.80
IV THERAPY	0.00	0.00
OPERATING ROOM	204,168.74	24,018.56
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30,850.20	42.60
ANESTHESIA	33,886.02	4,269.59
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,642,178.38	22,176.30
RECOVERY ROOM	39,997.00	5,881.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	73.90	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	107,056.50	0.00
BLOOD	99.70	0.00
BLOOD STORAGE & PRO.	0.00	4,734.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,067.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	100,082.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	154,420.20	5,499.50
OTHER LAB SERVICES	6,873.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	215,111.20	28,041.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,963.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,506,578.67	242,835.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,506,578.67	242,835.83

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	92,013.90	ADJUSTMENTS	0.00
COVERED CHARGES	82,800.17	CONTRACTUAL ALLOW	22,622.59
NON-COVERED CHARGES	9,213.73	TOTAL MEDICAID LIAB	60,177.58
		LESS: COB	60,150.58
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,187.33-
		FEE SCHEDULE-LAB	1,167.58
		INJECTABLE DRUGS	19.75

TOTAL NUMBER OF CLAIMS 88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,294.05	7,826.33
MED/SURG SUPPLY	7,519.20	0.00
LABORATORY-GENERAL	0.00	215.50
RADIOLOGY-DIAGNOSTIC	3,425.60	313.50
CT SCAN	7,962.40	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	647.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,695.70	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	158.40	0.00
ANESTHESIA	101.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,174.75	395.20
RECOVERY ROOM	1,238.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,453.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,042.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,677.40	246.20
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,358.10	217.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,800.17	9,213.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,800.17	9,213.73

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	102,611.60	ADJUSTMENTS	836.50
COVERED CHARGES	102,082.70	CONTRACTUAL ALLOW	88,331.20
NON-COVERED CHARGES	528.90	TOTAL MEDICAID LIAB	13,751.50
		LESS: COB	0.00
		LESS: COPAYMENT	348.00
		REIMBURSEMENT	13,403.50

TOTAL NUMBER OF CLAIMS 309

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,108.11	0.00
MED/SURG SUPPLY	4,285.60	0.00
LABORATORY-GENERAL	4,411.70	528.90
RADIOLOGY-DIAGNOSTIC	2,551.00	0.00
CT SCAN	2,985.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	327.10	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	124.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	78,265.55	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,738.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	284.94	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	102,082.70	528.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	102,082.70	528.90

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,411.79	ADJUSTMENTS	0.00
COVERED CHARGES	8,209.19	CONTRACTUAL ALLOW	6,327.20
NON-COVERED CHARGES	202.60	TOTAL MEDICAID LIAB	1,881.99
		LESS: COB	1,875.99
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498.21	0.00
MED/SURG SUPPLY	406.20	0.00
LABORATORY-GENERAL	947.40	172.60
RADIOLOGY-DIAGNOSTIC	80.30	0.00
CT SCAN	995.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	134.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,120.20	30.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.78	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,209.19	202.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,209.19	202.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW

THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	63,007.41	ADJUSTMENTS	0.00
COVERED CHARGES	58,475.20	CONTRACTUAL ALLOW	37,907.95
NON-COVERED CHARGES	4,532.21	TOTAL MEDICAID LIAB	20,567.25
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	20,558.25

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,072.50	3,196.81
MED/SURG SUPPLY	20,437.70	0.00
LABORATORY-GENERAL	0.00	11.40
RADIOLOGY-DIAGNOSTIC	211.90	0.00
CT SCAN	995.30	0.00
PHYSICAL THERAPY	0.00	306.40
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,387.10	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	133.00	0.00
ANESTHESIA	1,246.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,771.90	0.00
RECOVERY ROOM	1,643.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,053.50	984.80
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	383.10	32.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	139.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	58,475.20	4,532.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,475.20	4,532.21

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,249,771.32	ADJUSTMENTS	10,929.71
COVERED CHARGES	1,230,062.50	CONTRACTUAL ALLOW	548,572.47
NON-COVERED CHARGES	19,708.82	TOTAL MEDICAID LIAB	681,490.03
		LESS: COB	22,135.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	659,354.68

TOTAL NUMBER OF ADMISSIONS 137

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	375	0	154,405.00	15,782.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	375	0	154,405.00	15,782.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	80	0	81,840.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	80	0	81,840.00	0.00
TOTAL ACCOMODATIONS	455	0	236,245.00	15,782.00

INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,164.54	0.00
MED/SURG SUPPLY	250,695.05	1,387.22
LABORATORY-GENERAL	75,508.65	1,486.80
RADIOLOGY-DIAGNOSTIC	18,904.90	0.00
CT SCAN	23,346.30	0.00
PHYSICAL THERAPY	8,211.30	0.00
EKG/ECG	6,021.70	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	48,474.55	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	60,915.20	0.00
ANESTHESIA	6,601.16	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	142,141.15	0.00
RECOVERY ROOM	7,578.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,577.85	0.00
BLOOD	1,453.65	0.00
BLOOD STORAGE & PRO.	6,241.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,628.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	633.60	706.30
OTHER LAB SERVICES	3,373.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	346.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	180,345.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	993,817.50	3,926.82
TOTAL ACCOMODATIONS	236,245.00	15,782.00
TOTAL CHARGES	1,230,062.50	19,708.82

ZERO PAID INPATIENT PAID CLAIMS

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,438,528.12	ADJUSTMENTS	9,527.50
COVERED CHARGES	3,182,335.10	CONTRACTUAL ALLOW	2,315,567.49
NON-COVERED CHARGES	256,193.02	TOTAL MEDICAID LIAB	866,767.61
		LESS: COB	467.74
		LESS: COPAYMENT	2,019.00
		REIMBURSEMENT	864,280.87
		ALL OTHER	814,763.38
		FEE SCHEDULE-LAB	49,514.17
		INJECTABLE DRUGS	3.32

TOTAL NUMBER OF CLAIMS 3,905

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,798.87	126,881.03
MED/SURG SUPPLY	325,244.11	1,070.70
LABORATORY-GENERAL	147.00	7,168.80
RADIOLOGY-DIAGNOSTIC	147,697.50	3,302.90
CT SCAN	168,654.60	35,828.65
PHYSICAL THERAPY	406.20	0.00
EKG/ECG	29,954.40	682.90
IV THERAPY	0.00	0.00
OPERATING ROOM	178,860.40	12,741.30
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40,100.40	0.00
ANESTHESIA	17,203.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,520,033.40	25,660.35
RECOVERY ROOM	39,012.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,532.40	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	114,988.55	512.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,532.85
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,732.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	49,428.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	148,754.65	10,433.60
OTHER LAB SERVICES	7,176.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	217,597.50	30,269.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11.97	108.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,182,335.10	256,193.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,182,335.10	256,193.02

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	120,014.87	ADJUSTMENTS	0.00
COVERED CHARGES	107,693.48	CONTRACTUAL ALLOW	33,748.69
NON-COVERED CHARGES	12,321.39	TOTAL MEDICAID LIAB	73,944.79
		LESS: COB	73,908.79
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,808.11-
		FEE SCHEDULE-LAB	1,807.78
		INJECTABLE DRUGS	0.33

TOTAL NUMBER OF CLAIMS 95

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,876.58	4,650.64
MED/SURG SUPPLY	12,328.70	0.00
LABORATORY-GENERAL	0.00	240.75
RADIOLOGY-DIAGNOSTIC	4,485.65	0.00
CT SCAN	1,314.40	1,094.85
PHYSICAL THERAPY	0.00	164.60
EKG/ECG	800.70	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,346.25	4,412.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,007.50	59.20
ANESTHESIA	577.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,116.80	529.40
RECOVERY ROOM	1,362.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,479.95	367.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	789.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,493.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,829.90	132.00
OTHER LAB SERVICES	478.95	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,403.60	554.55
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	115.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	107,693.48	12,321.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	107,693.48	12,321.39

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	208,510.77	ADJUSTMENTS	135.75
COVERED CHARGES	205,409.24	CONTRACTUAL ALLOW	183,127.34
NON-COVERED CHARGES	3,101.53	TOTAL MEDICAID LIAB	22,281.90
		LESS: COB	73.16
		LESS: COPAYMENT	471.00
		REIMBURSEMENT	21,737.74

TOTAL NUMBER OF CLAIMS 490

OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,527.29	0.00
MED/SURG SUPPLY	10,795.80	8.78
LABORATORY-GENERAL	16,036.60	990.25
RADIOLOGY-DIAGNOSTIC	5,330.75	0.00
CT SCAN	3,284.55	1,094.85
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,220.45	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	676.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,648.90	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	145,377.50	198.55
RECOVERY ROOM	222.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,299.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	132.15
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,664.90	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	205,409.24	3,101.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,409.24	3,101.53

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	31,868.52	ADJUSTMENTS	0.00
COVERED CHARGES	30,713.32	CONTRACTUAL ALLOW	25,771.92
NON-COVERED CHARGES	1,155.20	TOTAL MEDICAID LIAB	4,941.40
		LESS: COB	4,941.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,873.77	0.00
MED/SURG SUPPLY	643.80	0.00
LABORATORY-GENERAL	1,412.85	56.70
RADIOLOGY-DIAGNOSTIC	510.05	0.00
CT SCAN	1,094.85	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	110.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,068.00	1,098.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,713.32	1,155.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,713.32	1,155.20

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW

THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	75,835.72	ADJUSTMENTS	0.00
COVERED CHARGES	69,575.69	CONTRACTUAL ALLOW	55,491.25
NON-COVERED CHARGES	6,260.03	TOTAL MEDICAID LIAB	14,084.44
		LESS: COB	2,392.30
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,686.14

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,997.30	4,086.04
MED/SURG SUPPLY	46,885.60	0.00
LABORATORY-GENERAL	0.00	6.30
RADIOLOGY-DIAGNOSTIC	434.40	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	517.50	172.50
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	10,157.41	1,774.54
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,476.48	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,022.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,927.75	98.05
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	157.25	122.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	69,575.69	6,260.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,575.69	6,260.03

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
TITLE XVIII NO: HOSP123

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,845.18	ADJUSTMENTS	0.00
COVERED CHARGES	21,309.76	CONTRACTUAL ALLOW	4,453.77
NON-COVERED CHARGES	2,535.42	TOTAL MEDICAID LIAB	16,855.99
		LESS: COB	16,855.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCDUFFIE REGIONAL MEDICAL CENTER
521 HILL ST SW
THOMSON GA 30824-0000

PROVIDER NUMBER 000001185A
NUMBER OF BEDS 47
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP123

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,166.53	1,278.60
MED/SURG SUPPLY	10,560.15	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	203.10
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,634.33	1,053.72
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,342.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	317.10	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,144.45	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,309.76	2,535.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,309.76	2,535.42

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,009,178.06	ADJUSTMENTS	12,204.76
COVERED CHARGES	10,896,493.91	CONTRACTUAL ALLOW	6,674,178.77
NON-COVERED CHARGES	112,684.15	TOTAL MEDICAID LIAB	4,222,315.14
		LESS: COB	27,308.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,195,006.25

TOTAL NUMBER OF ADMISSIONS 1,440

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,159	43	1,068,705.00	100,112.35
NURSERY CARE CHARGES	783	0	270,897.70	480.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	16	0.00	0.00
TOTAL ROUTINE	2,942	59	1,339,602.70	100,592.35
SPECIAL CARE SERVICES				
C C U	275	0	246,300.00	0.00
I C U	231	0	283,334.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	506	0	529,634.00	0.00
TOTAL ACCOMODATIONS	3,448	59	1,869,236.70	100,592.35

INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,210,767.91	0.00
MED/SURG SUPPLY	976,301.62	0.00
LABORATORY-GENERAL	1,195,966.62	536.50
RADIOLOGY-DIAGNOSTIC	101,735.80	0.00
CT SCAN	308,232.65	0.00
PHYSICAL THERAPY	22,978.20	0.00
EKG/ECG	78,971.75	0.00
IV THERAPY	39,014.00	0.00
OPERATING ROOM	1,103,076.06	0.00
LABOR/DELIVERY ROOM	947,382.45	0.00
RESPIRATORY SERVICES	215,824.30	0.00
ANESTHESIA	221,482.95	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	400,849.45	0.00
RECOVERY ROOM	241,557.95	0.00
LABORATORY PATHOLOGIC	43,355.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,694.70	0.00
SPEECH PATHOLOGY	3,914.10	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	237.60
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,043.25	0.00
OTHER IMAGING SERVICES	45,036.58	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	133,549.55	10,616.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,978.05	0.00
AUDIOLOGY	19,507.45	0.00
CARDIOLOGY	85,520.11	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	283.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	68,779.55	0.00
OTHER LAB SERVICES	52,365.85	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	31.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	43,589.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	414,498.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	669.10

TOTAL ANCILLARY	9,027,257.21	12,091.80
TOTAL ACCOMODATIONS	1,869,236.70	100,592.35
TOTAL CHARGES	10,896,493.91	112,684.15

ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	242,331.59	ADJUSTMENTS	0.00
COVERED CHARGES	239,047.49	CONTRACTUAL ALLOW	62,339.38
NON-COVERED CHARGES	3,284.10	TOTAL MEDICAID LIAB	176,708.11
		LESS: COB	176,708.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	62	0	30,690.00	2,099.30
NURSERY CARE CHARGES	5	0	1,700.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	32,390.00	2,099.30
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,150.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	1,150.00	0.00
TOTAL ACCOMODATIONS	68	0	33,540.00	2,099.30

ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,077.78	0.00
MED/SURG SUPPLY	15,846.88	0.00
LABORATORY-GENERAL	19,077.65	0.00
RADIOLOGY-DIAGNOSTIC	1,403.95	0.00
CT SCAN	3,813.25	0.00
PHYSICAL THERAPY	179.70	0.00
EKG/ECG	733.45	0.00
IV THERAPY	985.65	0.00
OPERATING ROOM	33,761.35	0.00
LABOR/DELIVERY ROOM	41,615.10	0.00
RESPIRATORY SERVICES	2,982.60	0.00
ANESTHESIA	6,900.65	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,788.50	0.00
RECOVERY ROOM	10,855.85	0.00
LABORATORY PATHOLOGIC	985.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	611.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,463.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	98.90	0.00
CARDIOLOGY	1,235.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,121.10	0.00
OTHER LAB SERVICES	871.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,184.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,097.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	205,507.49	1,184.80
TOTAL ACCOMODATIONS	33,540.00	2,099.30
TOTAL CHARGES	239,047.49	3,284.10

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	10,303,385.17	ADJUSTMENTS	107,054.79
COVERED CHARGES	9,848,094.99	CONTRACTUAL ALLOW	6,646,760.03
NON-COVERED CHARGES	455,290.18	TOTAL MEDICAID LIAB	3,201,334.96
		LESS: COB	1,982.92
		LESS: COPAYMENT	7,734.00
		REIMBURSEMENT	3,191,618.04
		ALL OTHER	2,992,556.15
		FEE SCHEDULE-LAB	176,641.98
		INJECTABLE DRUGS	22,419.91

TOTAL NUMBER OF CLAIMS 10,707

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	736,460.84	22,505.42
MED/SURG SUPPLY	463,317.08	497.36
LABORATORY-GENERAL	2,030.10	8,343.90
RADIOLOGY-DIAGNOSTIC	546,889.45	2,736.20
CT SCAN	1,134,461.05	7,791.05
PHYSICAL THERAPY	1,444.65	0.00
EKG/ECG	47,024.20	1,200.35
IV THERAPY	161,306.05	0.00
OPERATING ROOM	1,202,065.64	90,685.74
LABOR/DELIVERY ROOM	2,793.00	0.00
RESPIRATORY SERVICES	50,534.95	5,609.00
ANESTHESIA	222,967.80	2,910.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,236,193.92	27,012.25
RECOVERY ROOM	187,977.99	877.20
LABORATORY PATHOLOGIC	0.00	657.10
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	712.65	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,373.80	2,344.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	378,263.38	780.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	11,938.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	83,740.40	2,597.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	44,725.65	6,188.90
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,778.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	327,251.25	6,916.35
OTHER LAB SERVICES	312,798.66	477.90
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,188,844.74	194,940.98
MRI SERVICES	443,372.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64,766.74	57,094.34
HOME HEALTH SERVICES	0.00	45.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	80.34

TOTAL ANCILLARY	9,848,094.99	454,230.18
TOTAL ACCOMODATIONS	0.00	1,060.00
TOTAL CHARGES	9,848,094.99	455,290.18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	38,069.16	ADJUSTMENTS	0.00
COVERED CHARGES	22,153.70	CONTRACTUAL ALLOW	10,510.32
NON-COVERED CHARGES	15,915.46	TOTAL MEDICAID LIAB	11,643.38
		LESS: COB	11,625.38
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	406.99-
		FEE SCHEDULE-LAB	389.91
		INJECTABLE DRUGS	17.08

TOTAL NUMBER OF CLAIMS 157

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,634.13	0.00
MED/SURG SUPPLY	769.11	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,046.85	133.00
CT SCAN	3,789.40	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	87.25	0.00
IV THERAPY	690.10	0.00
OPERATING ROOM	351.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.05	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,272.90	308.95
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	276.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,216.95	0.00
OTHER LAB SERVICES	208.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,724.85	720.45
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52.96	14,753.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22,153.70	15,915.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,153.70	15,915.46

OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	891,496.94	ADJUSTMENTS	2,190.00
COVERED CHARGES	870,708.71	CONTRACTUAL ALLOW	781,385.36
NON-COVERED CHARGES	20,788.23	TOTAL MEDICAID LIAB	89,323.35
		LESS: COB	8.47
		LESS: COPAYMENT	1,692.00
		REIMBURSEMENT	87,622.88

TOTAL NUMBER OF CLAIMS 1,788

OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89,813.33	0.00
MED/SURG SUPPLY	14,469.54	0.00
LABORATORY-GENERAL	76,618.15	8,423.50
RADIOLOGY-DIAGNOSTIC	60,835.75	0.00
CT SCAN	45,228.80	0.00
PHYSICAL THERAPY	179.70	0.00
EKG/ECG	3,309.05	0.00
IV THERAPY	9,925.20	0.00
OPERATING ROOM	4,113.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,164.00	0.00
ANESTHESIA	907.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	538,702.95	1,151.75
RECOVERY ROOM	508.50	0.00
LABORATORY PATHOLOGIC	165.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	136.20
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	830.55	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,426.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,535.95	0.00
OTHER LAB SERVICES	4,432.05	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51.58	0.00
MRI SERVICES	4,320.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,597.01	8,650.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	870,708.71	20,788.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	870,708.71	20,788.23

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,011.84	ADJUSTMENTS	0.00
COVERED CHARGES	2,817.74	CONTRACTUAL ALLOW	2,126.92
NON-COVERED CHARGES	194.10	TOTAL MEDICAID LIAB	690.82
		LESS: COB	687.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	543.09	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	212.30	0.00
RADIOLOGY-DIAGNOSTIC	100.95	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11.55	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,949.85	194.10
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,817.74	194.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,817.74	194.10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	671,329.76	ADJUSTMENTS	15,696.00
COVERED CHARGES	659,857.26	CONTRACTUAL ALLOW	471,433.26
NON-COVERED CHARGES	11,472.50	TOTAL MEDICAID LIAB	188,424.00
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	188,340.00

TOTAL NUMBER OF CLAIMS 48

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,059.57	5,001.39
MED/SURG SUPPLY	125,915.85	0.00
LABORATORY-GENERAL	0.00	61.25
RADIOLOGY-DIAGNOSTIC	1,627.60	0.00
CT SCAN	7,845.70	0.00
PHYSICAL THERAPY	430.05	0.00
EKG/ECG	480.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	300,955.37	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	884.05	41.60
ANESTHESIA	67,620.00	1,452.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,717.25	0.00
RECOVERY ROOM	38,147.15	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,043.25	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	550.00	733.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,298.65	2,485.00
OTHER LAB SERVICES	108.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,424.65	693.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,749.52	1,004.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	659,857.26	11,472.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	659,857.26	11,472.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,270,678.41	ADJUSTMENTS	109,197.23
COVERED CHARGES	11,149,250.86	CONTRACTUAL ALLOW	6,967,228.51
NON-COVERED CHARGES	121,427.55	TOTAL MEDICAID LIAB	4,182,022.35
		LESS: COB	30,361.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,151,660.46

TOTAL NUMBER OF ADMISSIONS 1,440

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,251	36	1,193,030.00	92,280.00
NURSERY CARE CHARGES	829	0	296,110.00	865.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	14	0.00	0.00
TOTAL ROUTINE	3,080	50	1,489,140.00	93,145.00
SPECIAL CARE SERVICES				
C C U	219	0	202,900.00	0.00
I C U	158	0	201,050.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	377	0	403,950.00	0.00
TOTAL ACCOMODATIONS	3,457	50	1,893,090.00	93,145.00

INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,010,966.01	0.00
MED/SURG SUPPLY	922,589.17	0.00
LABORATORY-GENERAL	1,152,023.37	618.50
RADIOLOGY-DIAGNOSTIC	123,452.50	0.00
CT SCAN	400,714.99	0.00
PHYSICAL THERAPY	20,987.35	0.00
EKG/ECG	78,554.00	0.00
IV THERAPY	1,570.80	0.00
OPERATING ROOM	1,338,046.35	0.00
LABOR/DELIVERY ROOM	943,251.90	0.00
RESPIRATORY SERVICES	182,167.70	0.00
ANESTHESIA	273,223.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	480,653.30	0.00
RECOVERY ROOM	260,192.15	0.00
LABORATORY PATHOLOGIC	70,013.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,127.20	0.00
SPEECH PATHOLOGY	1,331.80	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	258.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,043.25	0.00
OTHER IMAGING SERVICES	57,864.39	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	123,200.20	17,984.65
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	34,649.80	0.00
AUDIOLOGY	20,422.75	0.00
CARDIOLOGY	78,105.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,481.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	86,972.65	0.00
OTHER LAB SERVICES	44,896.17	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	59,390.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,312.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	471,268.71	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,108.65

TOTAL ANCILLARY	9,256,160.86	28,282.55
TOTAL ACCOMODATIONS	1,893,090.00	93,145.00
TOTAL CHARGES	11,149,250.86	121,427.55

ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	283,056.17	ADJUSTMENTS	0.00
COVERED CHARGES	279,284.17	CONTRACTUAL ALLOW	84,958.09
NON-COVERED CHARGES	3,772.00	TOTAL MEDICAID LIAB	194,326.08
		LESS: COB	194,326.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	55	0	29,150.00	2,010.00
NURSERY CARE CHARGES	14	0	4,880.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	69	0	34,030.00	2,010.00
SPECIAL CARE SERVICES				
C C U	3	0	2,850.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	2,850.00	0.00
TOTAL ACCOMODATIONS	72	0	36,880.00	2,010.00

ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,022.71	0.00
MED/SURG SUPPLY	23,025.50	0.00
LABORATORY-GENERAL	12,584.25	0.00
RADIOLOGY-DIAGNOSTIC	579.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	60.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	65,175.25	0.00
LABOR/DELIVERY ROOM	54,335.00	0.00
RESPIRATORY SERVICES	973.20	0.00
ANESTHESIA	12,190.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,466.00	0.00
RECOVERY ROOM	12,619.50	0.00
LABORATORY PATHOLOGIC	1,622.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,350.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,833.00	954.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	346.15	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,836.30	0.00
OTHER LAB SERVICES	1,208.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	808.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,178.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	242,404.17	1,762.00
TOTAL ACCOMODATIONS	36,880.00	2,010.00
TOTAL CHARGES	279,284.17	3,772.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,795,487.16	ADJUSTMENTS	42,326.13
COVERED CHARGES	11,135,871.09	CONTRACTUAL ALLOW	7,893,047.40
NON-COVERED CHARGES	659,616.07	TOTAL MEDICAID LIAB	3,242,823.69
		LESS: COB	2,277.05
		LESS: COPAYMENT	7,677.00
		REIMBURSEMENT	3,232,869.64
		ALL OTHER	3,014,023.04
		FEE SCHEDULE-LAB	183,108.66
		INJECTABLE DRUGS	35,737.94

TOTAL NUMBER OF CLAIMS 11,661

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	744,778.48	2,474.69
MED/SURG SUPPLY	512,482.19	14,731.58
LABORATORY-GENERAL	822.10	9,378.60
RADIOLOGY-DIAGNOSTIC	609,196.05	3,719.25
CT SCAN	1,470,350.35	41,892.55
PHYSICAL THERAPY	40,050.20	540.00
EKG/ECG	50,857.75	1,309.25
IV THERAPY	5,426.40	0.00
OPERATING ROOM	1,423,612.70	42,636.10
LABOR/DELIVERY ROOM	11,855.00	0.00
RESPIRATORY SERVICES	40,405.40	6,393.20
ANESTHESIA	212,062.00	1,524.75
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,533,146.00	105,696.65
RECOVERY ROOM	196,090.75	1,104.00
LABORATORY PATHOLOGIC	0.00	575.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,861.50	0.00
SPEECH PATHOLOGY	5,417.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,664.00	2,410.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	371,718.49	3,182.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	636.00	27,002.55
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	128,333.00	6,805.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	67,344.50	27,746.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	197,466.41	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	356,024.95	48,849.05
OTHER LAB SERVICES	227,925.77	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,356,797.04	211,717.29
MRI SERVICES	451,239.20	1,390.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	114,307.11	74,381.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	23,974.32

TOTAL ANCILLARY	11,135,871.09	659,434.32
TOTAL ACCOMODATIONS	0.00	181.75
TOTAL CHARGES	11,135,871.09	659,616.07

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	27,176.84	ADJUSTMENTS	0.00
COVERED CHARGES	21,084.24	CONTRACTUAL ALLOW	7,022.57
NON-COVERED CHARGES	6,092.60	TOTAL MEDICAID LIAB	14,061.67
		LESS: COB	14,055.67
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	637.05-
		FEE SCHEDULE-LAB	588.93
		INJECTABLE DRUGS	48.12

TOTAL NUMBER OF CLAIMS 29

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,416.73	0.00
MED/SURG SUPPLY	683.18	0.00
LABORATORY-GENERAL	0.00	215.25
RADIOLOGY-DIAGNOSTIC	656.00	115.00
CT SCAN	3,910.40	4,130.00
PHYSICAL THERAPY	780.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,968.15	446.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	32.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	795.00	350.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,524.80	0.00
OTHER LAB SERVICES	229.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	57.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,966.58	430.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	317.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	154.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,084.24	6,092.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,084.24	6,092.60

OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	920,634.46	ADJUSTMENTS	444.00
COVERED CHARGES	894,386.51	CONTRACTUAL ALLOW	803,561.11
NON-COVERED CHARGES	26,247.95	TOTAL MEDICAID LIAB	90,825.40
		LESS: COB	0.00
		LESS: COPAYMENT	2,412.00
		REIMBURSEMENT	88,413.40

TOTAL NUMBER OF CLAIMS 1,817

OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,319.55	0.00
MED/SURG SUPPLY	19,516.31	3.14
LABORATORY-GENERAL	101,415.50	5,918.95
RADIOLOGY-DIAGNOSTIC	39,353.40	0.00
CT SCAN	43,359.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,541.00	0.00
IV THERAPY	428.40	0.00
OPERATING ROOM	8,030.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,326.35	0.00
ANESTHESIA	953.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	584,454.15	19,079.50
RECOVERY ROOM	1,259.00	0.00
LABORATORY PATHOLOGIC	239.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	35.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,258.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	309.10	118.75
OTHER LAB SERVICES	1,552.09	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51.58	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,019.38	1,092.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	894,386.51	26,247.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	894,386.51	26,247.95

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,832.30	ADJUSTMENTS	0.00
COVERED CHARGES	13,675.50	CONTRACTUAL ALLOW	12,224.08
NON-COVERED CHARGES	2,156.80	TOTAL MEDICAID LIAB	1,451.42
		LESS: COB	1,448.42
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,677.86	0.00
MED/SURG SUPPLY	229.52	0.00
LABORATORY-GENERAL	2,567.10	119.95
RADIOLOGY-DIAGNOSTIC	995.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,851.75	1,946.85
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	345.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,798.55	86.00
OTHER LAB SERVICES	125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	73.72	4.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,675.50	2,156.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,675.50	2,156.80

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE

VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	895,626.25	ADJUSTMENTS	3,360.23
COVERED CHARGES	861,390.00	CONTRACTUAL ALLOW	665,900.00
NON-COVERED CHARGES	34,236.25	TOTAL MEDICAID LIAB	195,490.00
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	195,340.00

TOTAL NUMBER OF CLAIMS 57

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0078GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,045.03	32.55
MED/SURG SUPPLY	145,905.73	16,562.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,992.00	192.00
CT SCAN	4,350.00	0.00
PHYSICAL THERAPY	179.70	0.00
EKG/ECG	97.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	360,725.00	11,380.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	485.20	72.00
ANESTHESIA	90,047.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,368.00	476.00
RECOVERY ROOM	44,966.00	0.00
LABORATORY PATHOLOGIC	0.00	1,050.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	99,389.25	0.00
OTHER IMAGING SERVICES	1,060.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,245.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,342.75	3,240.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,056.15	1,231.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,135.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	861,390.00	34,236.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	861,390.00	34,236.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MED CTR, INCHOSP
1703 MEADOWS LANE
VIDALIA GA 30474-8915

PROVIDER NUMBER 000001086A
NUMBER OF BEDS 77
TITLE XVIII NO: HPH0078GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	127,113,339.48	ADJUSTMENTS	8,553,163.85
COVERED CHARGES	123,786,415.70	CONTRACTUAL ALLOW	72,955,448.66
NON-COVERED CHARGES	3,326,923.78	TOTAL MEDICAID LIAB	50,830,967.04
		LESS: COB	207,126.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	50,623,840.59

TOTAL NUMBER OF ADMISSIONS 7,181

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21,726	0	13,057,326.00	1,468,073.00
NURSERY CARE CHARGES	5,613	0	2,051,925.00	870,087.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	172	0.00	0.00
TOTAL ROUTINE	27,339	172	15,109,251.00	2,338,160.00
SPECIAL CARE SERVICES				
C C U	3	0	1,932.00	0.00
I C U	2,217	0	3,527,247.00	0.00
N I C U	8,147	0	13,000,860.00	0.00
PED I C U	1,647	0	2,577,055.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	12,014	0	19,107,094.00	0.00
TOTAL ACCOMODATIONS	39,353	172	34,216,345.00	2,338,160.00

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,417,993.35	8,198.08
MED/SURG SUPPLY	8,597,558.77	9,940.00
LABORATORY-GENERAL	12,811,714.73	19,418.00
RADIOLOGY-DIAGNOSTIC	1,919,014.00	0.00
CT SCAN	1,884,908.00	723,524.00
PHYSICAL THERAPY	189,270.00	0.00
EKG/ECG	951,905.00	0.00
IV THERAPY	2,703.00	1,113.00
OPERATING ROOM	2,845,558.00	0.00
LABOR/DELIVERY ROOM	5,688,568.00	0.00
RESPIRATORY SERVICES	11,049,141.00	0.00
ANESTHESIA	1,464,025.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,106,155.00	0.00
RECOVERY ROOM	515,364.00	0.00
LABORATORY PATHOLOGIC	214,138.95	182.00
RADIOLOGY THERAPEUTIC	64,798.00	37,517.00
OCCUPATIONAL THERAPY	135,398.00	0.00
SPEECH PATHOLOGY	144,975.00	0.00
RENAL DIALYSIS	365,737.00	6,229.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	31,554.00
PSYCHIATRIC SERVICES	66,639.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	421,123.00	4,580.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,220,570.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	188,509.00	0.00
AUDIOLOGY	186,501.00	98.00
CARDIOLOGY	4,132,372.00	0.00
AMBULATORY SURGERY	39,342.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	82,021.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	647,699.00	8,895.00
OTHER LAB SERVICES	154,848.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	145.00	35,755.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	839,393.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	13,987.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	339.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	221,644.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	87,773.70

TOTAL ANCILLARY	89,570,070.70	988,763.78
TOTAL ACCOMODATIONS	34,216,345.00	2,338,160.00
TOTAL CHARGES	123,786,415.70	3,326,923.78

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,675,144.93	ADJUSTMENTS	0.00
COVERED CHARGES	1,636,891.93	CONTRACTUAL ALLOW	901,714.86
NON-COVERED CHARGES	38,253.00	TOTAL MEDICAID LIAB	735,177.07
		LESS: COB	735,177.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	166	0	99,766.00	10,568.00
NURSERY CARE CHARGES	27	0	16,227.00	11,097.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	193	0	115,993.00	21,665.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	81	0	128,871.00	0.00
N I C U	92	0	146,832.00	0.00
PED I C U	6	0	8,630.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	179	0	284,333.00	0.00
TOTAL ACCOMODATIONS	372	0	400,326.00	21,665.00

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	434,693.83	0.00
MED/SURG SUPPLY	116,960.10	411.00
LABORATORY-GENERAL	145,122.00	246.00
RADIOLOGY-DIAGNOSTIC	29,311.00	0.00
CT SCAN	43,868.00	7,644.00
PHYSICAL THERAPY	5,372.00	0.00
EKG/ECG	7,670.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,394.00	0.00
LABOR/DELIVERY ROOM	54,241.00	0.00
RESPIRATORY SERVICES	262,877.00	0.00
ANESTHESIA	15,205.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,068.00	0.00
RECOVERY ROOM	2,679.00	0.00
LABORATORY PATHOLOGIC	1,518.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,760.00	0.00
SPEECH PATHOLOGY	5,618.00	0.00
RENAL DIALYSIS	3,584.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	228.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,747.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,455.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	904.00	0.00
AUDIOLOGY	392.00	0.00
CARDIOLOGY	29,646.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	385.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,809.00	1,797.00
OTHER LAB SERVICES	2,212.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,847.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,286.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,204.00

TOTAL ANCILLARY	1,236,565.93	16,588.00
TOTAL ACCOMODATIONS	400,326.00	21,665.00
TOTAL CHARGES	1,636,891.93	38,253.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	40,750,253.14	ADJUSTMENTS	1,340,501.00
COVERED CHARGES	38,004,607.08	CONTRACTUAL ALLOW	18,733,628.44
NON-COVERED CHARGES	2,745,646.06	TOTAL MEDICAID LIAB	19,270,978.64
		LESS: COB	31,785.28
		LESS: COPAYMENT	78,381.00
		REIMBURSEMENT	19,160,812.36
		ALL OTHER	16,823,775.12
		FEE SCHEDULE-LAB	2,336,550.86
		INJECTABLE DRUGS	486.38

TOTAL NUMBER OF CLAIMS 71,075

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,365,445.04	47,942.70
MED/SURG SUPPLY	1,620,113.37	13,663.00
LABORATORY-GENERAL	18,766.00	189,532.50
RADIOLOGY-DIAGNOSTIC	1,863,070.80	66,304.00
CT SCAN	1,849,695.00	197,676.00
PHYSICAL THERAPY	230,416.00	20,038.00
EKG/ECG	253,854.00	4,556.00
IV THERAPY	11,270.00	5,247.00
OPERATING ROOM	3,290,932.00	134,377.00
LABOR/DELIVERY ROOM	788,861.00	3,082.00
RESPIRATORY SERVICES	303,436.00	3,843.00
ANESTHESIA	812,049.00	4,483.00
GI SERVICES	11,715.00	0.00
EMERGENCY ROOM	3,205,363.00	45,281.00
RECOVERY ROOM	943,006.00	4,328.00
LABORATORY PATHOLOGIC	0.00	321.00
RADIOLOGY THERAPEUTIC	115,033.00	8,820.00
OCCUPATIONAL THERAPY	113,329.00	10,754.00
SPEECH PATHOLOGY	79,091.00	1,393.00
RENAL DIALYSIS	0.00	2,969.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,804,256.00	1,959.00
PSYCHIATRIC SERVICES	76.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	542,649.00	49,780.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	138,394.00	14,407.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	424,766.40	10,074.00
AUDIOLOGY	392.00	0.00
CARDIOLOGY	611,614.00	74,519.00
AMBULATORY SURGERY	16,831.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	70,962.00	410.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,799,192.70	36,636.00
OTHER LAB SERVICES	182,410.00	37.00
RECREATIONAL THERAPY	27.00	0.00
EDUCATION & TRAINING	1,374.00	0.00
OTHER THERAPEUTIC SERVI	62,768.00	7,657.00
SPECIAL CHARGES	13.90	0.00
FEE SCHEDULE LAB	9,399,303.37	1,729,205.26
MRI SERVICES	58,581.00	2,050.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	10,364.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	12,307.00	678.00
FREE STANDING CLINIC	0.00	105.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,244.50	73.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42,425.00

TOTAL ANCILLARY	38,004,607.08	2,744,990.06
TOTAL ACCOMODATIONS	0.00	656.00
TOTAL CHARGES	38,004,607.08	2,745,646.06

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	96,110.66	ADJUSTMENTS	0.00
COVERED CHARGES	78,868.46	CONTRACTUAL ALLOW	27,781.42
NON-COVERED CHARGES	17,242.20	TOTAL MEDICAID LIAB	51,087.04
		LESS: COB	50,817.04
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	0.00
		ALL OTHER	4,287.15-
		FEE SCHEDULE-LAB	4,287.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 212

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,595.30	744.20
MED/SURG SUPPLY	5,439.00	87.00
LABORATORY-GENERAL	0.00	3,388.00
RADIOLOGY-DIAGNOSTIC	2,824.00	2,397.00
CT SCAN	791.00	1,582.00
PHYSICAL THERAPY	250.00	190.00
EKG/ECG	92.00	92.00
IV THERAPY	159.00	0.00
OPERATING ROOM	10,446.00	0.00
LABOR/DELIVERY ROOM	1,461.00	249.00
RESPIRATORY SERVICES	311.00	0.00
ANESTHESIA	2,926.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,461.00	397.00
RECOVERY ROOM	2,873.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	178.00	0.00
OCCUPATIONAL THERAPY	153.00	0.00
SPEECH PATHOLOGY	0.00	301.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,792.00	292.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	617.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	266.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	836.00	611.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	385.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,802.00	0.00
OTHER LAB SERVICES	125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	34.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,352.16	4,099.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,225.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	78,868.46	15,954.20
TOTAL ACCOMODATIONS	0.00	1,288.00
TOTAL CHARGES	78,868.46	17,242.20

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,184,997.60	ADJUSTMENTS	2,344.58
COVERED CHARGES	1,085,754.00	CONTRACTUAL ALLOW	997,622.88
NON-COVERED CHARGES	99,243.60	TOTAL MEDICAID LIAB	88,131.12
		LESS: COB	7.42
		LESS: COPAYMENT	1,743.00
		REIMBURSEMENT	86,380.70

TOTAL NUMBER OF CLAIMS 1,763

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,527.90	140.60
MED/SURG SUPPLY	33,555.00	507.00
LABORATORY-GENERAL	235,788.00	69,880.00
RADIOLOGY-DIAGNOSTIC	88,353.00	333.00
CT SCAN	68,041.00	21,703.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	15,092.00	0.00
IV THERAPY	0.00	159.00
OPERATING ROOM	4,984.00	1,852.00
LABOR/DELIVERY ROOM	1,245.00	0.00
RESPIRATORY SERVICES	4,717.00	0.00
ANESTHESIA	1,398.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	491,103.00	0.00
RECOVERY ROOM	1,970.00	0.00
LABORATORY PATHOLOGIC	104.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,959.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,621.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	876.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	922.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,549.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,440.00	3,562.00
OTHER LAB SERVICES	1,254.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,219.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,107.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,085,754.00	99,243.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,085,754.00	99,243.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,519.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,436.50	CONTRACTUAL ALLOW	673.38
NON-COVERED CHARGES	1,083.00	TOTAL MEDICAID LIAB	763.12
		LESS: COB	757.12
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104.50	0.00
MED/SURG SUPPLY	75.00	32.00
LABORATORY-GENERAL	360.00	399.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	897.00	299.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	353.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,436.50	1,083.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,436.50	1,083.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,488,462.15	ADJUSTMENTS	396,077.19
COVERED CHARGES	7,273,451.35	CONTRACTUAL ALLOW	4,384,044.28
NON-COVERED CHARGES	215,010.80	TOTAL MEDICAID LIAB	2,889,407.07
		LESS: COB	3,727.13
		LESS: COPAYMENT	1,428.00
		REIMBURSEMENT	2,884,251.94

TOTAL NUMBER OF CLAIMS 608

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,959,052.72	9,668.30
MED/SURG SUPPLY	833,368.48	1,392.00
LABORATORY-GENERAL	1,466.00	4,467.00
RADIOLOGY-DIAGNOSTIC	302,892.60	13,813.20
CT SCAN	97,053.00	13,558.00
PHYSICAL THERAPY	1,577.00	0.00
EKG/ECG	38,902.00	0.00
IV THERAPY	1,005.00	0.00
OPERATING ROOM	355,324.00	28,878.00
LABOR/DELIVERY ROOM	498.00	0.00
RESPIRATORY SERVICES	32,181.00	45.00
ANESTHESIA	119,452.00	1,465.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	69,076.00	0.00
RECOVERY ROOM	92,181.00	0.00
LABORATORY PATHOLOGIC	0.00	125.00
RADIOLOGY THERAPEUTIC	54,484.00	47,706.00
OCCUPATIONAL THERAPY	195.00	0.00
SPEECH PATHOLOGY	599.00	0.00
RENAL DIALYSIS	0.00	4,480.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,243.00	0.00
PSYCHIATRIC SERVICES	380.00	50.00
LITHOTRIPSY	82,431.00	0.00
OTHER IMAGING SERVICES	12,154.00	766.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,175.00	1,268.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,007.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,600,300.00	9,320.00
AMBULATORY SURGERY	11,634.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	820.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	266,791.00	938.00
OTHER LAB SERVICES	18,445.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	9,707.00	2,834.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	238,177.55	62,620.60
MRI SERVICES	25,430.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,450.00	149.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11,467.00

TOTAL ANCILLARY	7,273,451.35	215,010.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,273,451.35	215,010.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	18,128.10	ADJUSTMENTS	0.00
COVERED CHARGES	16,928.10	CONTRACTUAL ALLOW	12,406.10
NON-COVERED CHARGES	1,200.00	TOTAL MEDICAID LIAB	4,522.00
		LESS: COB	4,522.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	769.10	0.00
MED/SURG SUPPLY	837.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	922.00	0.00
CT SCAN	5,088.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	476.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	993.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,767.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	325.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,174.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,577.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,200.00
TOTAL ANCILLARY	16,928.10	1,200.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,928.10	1,200.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	155,932,364.17	ADJUSTMENTS	13,088,857.61
COVERED CHARGES	152,953,484.27	CONTRACTUAL ALLOW	93,194,017.13
NON-COVERED CHARGES	2,978,879.90	TOTAL MEDICAID LIAB	59,759,467.14
		LESS: COB	377,819.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	59,381,647.51

TOTAL NUMBER OF ADMISSIONS 7,824

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	24,295	0	14,859,811.00	1,519,583.00
NURSERY CARE CHARGES	6,198	0	2,357,585.00	1,005,748.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	189	0.00	0.00
TOTAL ROUTINE	30,493	189	17,217,396.00	2,525,331.00
SPECIAL CARE SERVICES				
C C U	13	0	8,372.00	0.00
I C U	2,603	0	4,138,571.00	0.00
N I C U	8,153	0	13,010,769.00	0.00
PED I C U	2,069	0	3,160,224.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	12,838	0	20,317,936.00	0.00
TOTAL ACCOMODATIONS	43,331	189	37,535,332.00	2,525,331.00

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,285,619.92	2,341.90
MED/SURG SUPPLY	11,153,710.25	37,635.00
LABORATORY-GENERAL	15,935,063.24	27,713.00
RADIOLOGY-DIAGNOSTIC	2,544,726.55	0.00
CT SCAN	3,733,232.00	0.00
PHYSICAL THERAPY	252,136.00	0.00
EKG/ECG	1,188,953.00	0.00
IV THERAPY	14,500.00	0.00
OPERATING ROOM	3,501,163.00	0.00
LABOR/DELIVERY ROOM	7,451,053.00	0.00
RESPIRATORY SERVICES	13,141,455.00	0.00
ANESTHESIA	1,688,670.00	0.00
GI SERVICES	1,643.00	0.00
EMERGENCY ROOM	3,112,697.00	0.00
RECOVERY ROOM	650,941.00	0.00
LABORATORY PATHOLOGIC	285,593.81	0.00
RADIOLOGY THERAPEUTIC	52,421.00	11,564.00
OCCUPATIONAL THERAPY	150,812.00	0.00
SPEECH PATHOLOGY	168,900.00	0.00
RENAL DIALYSIS	516,520.00	51,611.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	49,099.00
PSYCHIATRIC SERVICES	92,217.00	0.00
LITHOTRIPSY	9,617.00	0.00
OTHER IMAGING SERVICES	525,999.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,487,402.00	1,808.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	293,334.00	0.00
AUDIOLOGY	202,372.00	103.00
CARDIOLOGY	4,977,639.00	0.00
AMBULATORY SURGERY	30,863.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	70,386.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,237,347.00	21,860.00
OTHER LAB SERVICES	251,661.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	6,627.00	877.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,027,846.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	11,766.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	46.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	375,032.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	237,125.00

TOTAL ANCILLARY	115,418,152.27	453,548.90
TOTAL ACCOMODATIONS	37,535,332.00	2,525,331.00
TOTAL CHARGES	152,953,484.27	2,978,879.90

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	736,935.22	ADJUSTMENTS	0.00
COVERED CHARGES	711,490.22	CONTRACTUAL ALLOW	196,615.70
NON-COVERED CHARGES	25,445.00	TOTAL MEDICAID LIAB	514,874.52
		LESS: COB	514,874.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	101	0	61,733.00	6,937.00
NURSERY CARE CHARGES	19	0	11,419.00	7,809.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	120	0	73,152.00	14,746.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,591.00	0.00
N I C U	87	0	138,852.00	0.00
PED I C U	7	0	11,172.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	95	0	151,615.00	0.00
TOTAL ACCOMODATIONS	215	0	224,767.00	14,746.00

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,465.81	0.00
MED/SURG SUPPLY	20,794.00	221.00
LABORATORY-GENERAL	70,941.41	86.00
RADIOLOGY-DIAGNOSTIC	9,979.00	0.00
CT SCAN	13,062.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	821.00	0.00
IV THERAPY	183.00	0.00
OPERATING ROOM	10,208.00	0.00
LABOR/DELIVERY ROOM	74,342.00	0.00
RESPIRATORY SERVICES	80,936.00	0.00
ANESTHESIA	13,558.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,748.00	0.00
RECOVERY ROOM	1,641.00	0.00
LABORATORY PATHOLOGIC	1,836.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	349.00
PSYCHIATRIC SERVICES	1,721.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,444.00	0.00
BLOOD	21.00	0.00
BLOOD STORAGE & PRO.	5,085.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	309.00	0.00
CARDIOLOGY	7,627.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,357.00	0.00
OTHER LAB SERVICES	1,335.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,125.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,583.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	184.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,460.00

TOTAL ANCILLARY	486,723.22	10,699.00
TOTAL ACCOMODATIONS	224,767.00	14,746.00
TOTAL CHARGES	711,490.22	25,445.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	45,781,393.97	ADJUSTMENTS	3,438,279.13
COVERED CHARGES	43,176,934.93	CONTRACTUAL ALLOW	23,222,109.26
NON-COVERED CHARGES	2,604,459.04	TOTAL MEDICAID LIAB	19,954,825.67
		LESS: COB	42,376.41
		LESS: COPAYMENT	71,661.00
		REIMBURSEMENT	19,840,788.26
		ALL OTHER	17,516,989.21
		FEE SCHEDULE-LAB	2,323,799.05
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 73,120

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,731,198.74	16,111.57
MED/SURG SUPPLY	1,515,110.61	15,851.00
LABORATORY-GENERAL	63,268.00	348,460.34
RADIOLOGY-DIAGNOSTIC	2,015,935.73	31,805.00
CT SCAN	2,618,110.00	22,572.00
PHYSICAL THERAPY	263,213.60	8,481.00
EKG/ECG	308,745.00	485.00
IV THERAPY	180,654.00	560.00
OPERATING ROOM	3,363,473.00	16,791.00
LABOR/DELIVERY ROOM	1,320,264.00	19,970.00
RESPIRATORY SERVICES	488,844.00	2,242.00
ANESTHESIA	801,094.00	5,914.00
GI SERVICES	10,414.00	0.00
EMERGENCY ROOM	3,619,268.00	8,851.00
RECOVERY ROOM	944,739.00	548.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	109,521.00	2,545.00
OCCUPATIONAL THERAPY	116,446.00	4,929.00
SPEECH PATHOLOGY	67,684.00	771.00
RENAL DIALYSIS	0.00	941.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,316,667.00	1,751.00
PSYCHIATRIC SERVICES	0.00	327.00
LITHOTRIPSY	9,617.00	0.00
OTHER IMAGING SERVICES	597,450.00	6,542.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	289,757.00	14,398.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	560,687.40	7,227.00
AUDIOLOGY	3,090.00	0.00
CARDIOLOGY	596,848.00	1,643.00
AMBULATORY SURGERY	4,091.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	165,832.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,478,344.00	24,254.00
OTHER LAB SERVICES	203,455.00	112.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	276.00	0.00
OTHER THERAPEUTIC SERVI	112,897.00	4,466.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,227,291.65	1,931,065.53
MRI SERVICES	64,341.00	2,153.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	9,787.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	8,113.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	548.00
HOME HEALTH SERVICES	0.00	490.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	195.20	90,387.70

TOTAL ANCILLARY	43,176,934.93	2,602,979.14
TOTAL ACCOMODATIONS	0.00	1,479.90
TOTAL CHARGES	43,176,934.93	2,604,459.04

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	194,748.55	ADJUSTMENTS	0.00
COVERED CHARGES	171,196.05	CONTRACTUAL ALLOW	76,612.47
NON-COVERED CHARGES	23,552.50	TOTAL MEDICAID LIAB	94,583.58
		LESS: COB	94,367.58
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	0.00
		ALL OTHER	8,324.86-
		FEE SCHEDULE-LAB	8,324.86
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 314

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,947.60	107.50
MED/SURG SUPPLY	7,543.00	221.00
LABORATORY-GENERAL	192.00	3,660.00
RADIOLOGY-DIAGNOSTIC	8,942.00	190.00
CT SCAN	11,386.00	0.00
PHYSICAL THERAPY	477.00	636.00
EKG/ECG	1,132.00	0.00
IV THERAPY	646.00	0.00
OPERATING ROOM	11,030.00	1,077.00
LABOR/DELIVERY ROOM	5,469.00	520.00
RESPIRATORY SERVICES	1,871.00	244.00
ANESTHESIA	2,041.00	651.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,316.00	0.00
RECOVERY ROOM	4,196.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	127.00	0.00
OCCUPATIONAL THERAPY	583.00	159.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,023.00	266.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,920.00	174.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	742.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,486.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	835.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,359.00	289.00
OTHER LAB SERVICES	1,266.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	359.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,666.45	11,781.00
MRI SERVICES	0.00	1,903.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,205.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	171,196.05	23,442.50
TOTAL ACCOMODATIONS	0.00	110.00
TOTAL CHARGES	171,196.05	23,552.50

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	951,643.55	ADJUSTMENTS	6,725.00
COVERED CHARGES	889,708.95	CONTRACTUAL ALLOW	822,458.95
NON-COVERED CHARGES	61,934.60	TOTAL MEDICAID LIAB	67,250.00
		LESS: COB	34.29
		LESS: COPAYMENT	1,755.00
		REIMBURSEMENT	65,460.71

TOTAL NUMBER OF CLAIMS 1,345

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,166.20	8.60
MED/SURG SUPPLY	12,693.75	940.00
LABORATORY-GENERAL	173,402.00	57,741.00
RADIOLOGY-DIAGNOSTIC	85,993.00	693.00
CT SCAN	85,467.00	946.00
PHYSICAL THERAPY	818.00	0.00
EKG/ECG	10,986.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	231.00	0.00
LABOR/DELIVERY ROOM	522.00	0.00
RESPIRATORY SERVICES	25,880.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	400,719.00	1,077.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	446.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,001.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,189.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,632.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	968.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	341.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,551.00	0.00
OTHER LAB SERVICES	1,800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,903.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	529.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	889,708.95	61,934.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	889,708.95	61,934.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,045.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,717.00	CONTRACTUAL ALLOW	2,292.48
NON-COVERED CHARGES	1,328.00	TOTAL MEDICAID LIAB	4,424.52
		LESS: COB	4,418.52
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312.00	0.00
MED/SURG SUPPLY	68.00	0.00
LABORATORY-GENERAL	875.00	322.00
RADIOLOGY-DIAGNOSTIC	606.00	106.00
CT SCAN	2,819.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	47.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,990.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	900.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,717.00	1,328.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,717.00	1,328.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,237,593.98	ADJUSTMENTS	800,325.78
COVERED CHARGES	10,953,986.31	CONTRACTUAL ALLOW	7,465,363.73
NON-COVERED CHARGES	283,607.67	TOTAL MEDICAID LIAB	3,488,622.58
		LESS: COB	0.00
		LESS: COPAYMENT	1,743.00
		REIMBURSEMENT	3,486,879.58

TOTAL NUMBER OF CLAIMS 748

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,075,203.65	14,137.03
MED/SURG SUPPLY	1,505,143.41	3,049.00
LABORATORY-GENERAL	4,101.00	3,000.00
RADIOLOGY-DIAGNOSTIC	478,268.00	56,371.00
CT SCAN	201,043.00	1,995.00
PHYSICAL THERAPY	3,196.00	192.00
EKG/ECG	66,902.00	0.00
IV THERAPY	11,298.00	0.00
OPERATING ROOM	437,482.00	6,967.00
LABOR/DELIVERY ROOM	1,042.00	0.00
RESPIRATORY SERVICES	58,534.00	0.00
ANESTHESIA	142,860.00	2,772.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	184,616.00	0.00
RECOVERY ROOM	102,458.00	0.00
LABORATORY PATHOLOGIC	0.00	61.00
RADIOLOGY THERAPEUTIC	80,409.00	6,795.00
OCCUPATIONAL THERAPY	765.00	0.00
SPEECH PATHOLOGY	215.00	0.00
RENAL DIALYSIS	0.00	1,882.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,935.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	24,043.00	0.00
OTHER IMAGING SERVICES	22,203.00	804.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,328.00	2,827.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	58,811.00	0.00
AUDIOLOGY	103.00	0.00
CARDIOLOGY	2,479,234.00	23,915.00
AMBULATORY SURGERY	5,183.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,266.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	503,664.00	9,781.00
OTHER LAB SERVICES	26,211.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	12,401.00	276.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	406,007.25	123,083.64
MRI SERVICES	37,061.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	23,100.00

TOTAL ANCILLARY	10,953,986.31	281,007.67
TOTAL ACCOMODATIONS	0.00	2,600.00
TOTAL CHARGES	10,953,986.31	283,607.67

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	31,123.90	ADJUSTMENTS	0.00
COVERED CHARGES	26,481.90	CONTRACTUAL ALLOW	4,644.70
NON-COVERED CHARGES	4,642.00	TOTAL MEDICAID LIAB	21,837.20
		LESS: COB	21,837.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	749.90	0.00
MED/SURG SUPPLY	2,018.00	221.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,311.00	141.00
CT SCAN	9,896.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	291.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,382.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,310.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,524.00	920.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,360.00

TOTAL ANCILLARY	26,481.90	4,642.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,481.90	4,642.00

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	160,278,434.72	ADJUSTMENTS	15,148,658.91
COVERED CHARGES	158,587,666.22	CONTRACTUAL ALLOW	100,419,165.39
NON-COVERED CHARGES	1,690,768.50	TOTAL MEDICAID LIAB	58,168,500.83
		LESS: COB	220,193.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	57,948,307.58

TOTAL NUMBER OF ADMISSIONS 6,373

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21,372	0	13,763,568.00	530,602.00
NURSERY CARE CHARGES	4,695	0	1,919,718.00	761,084.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	200	0.00	0.00
TOTAL ROUTINE	26,067	200	15,683,286.00	1,291,686.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3,979	0	5,788,402.00	0.00
N I C U	7,066	0	11,277,336.00	0.00
PED I C U	2,311	0	3,687,883.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	13,356	0	20,753,621.00	0.00
TOTAL ACCOMODATIONS	39,423	200	36,436,907.00	1,291,686.00

INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,717,447.25	2,102.50
MED/SURG SUPPLY	13,414,620.80	40,780.00
LABORATORY-GENERAL	15,992,274.06	3,374.00
RADIOLOGY-DIAGNOSTIC	2,321,149.00	0.00
CT SCAN	3,941,394.00	0.00
PHYSICAL THERAPY	223,610.03	0.00
EKG/ECG	1,299,549.20	0.00
IV THERAPY	8,136.00	0.00
OPERATING ROOM	3,450,124.00	0.00
LABOR/DELIVERY ROOM	5,968,791.00	0.00
RESPIRATORY SERVICES	15,062,160.00	0.00
ANESTHESIA	1,262,366.00	0.00
GI SERVICES	1,428.00	0.00
EMERGENCY ROOM	3,585,590.00	0.00
RECOVERY ROOM	616,781.00	0.00
LABORATORY PATHOLOGIC	274,326.14	0.00
RADIOLOGY THERAPEUTIC	65,402.00	0.00
OCCUPATIONAL THERAPY	127,620.00	0.00
SPEECH PATHOLOGY	203,441.00	0.00
RENAL DIALYSIS	483,082.00	44,914.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	37,131.00
PSYCHIATRIC SERVICES	61,504.00	0.00
LITHOTRIPSY	5,313.00	0.00
OTHER IMAGING SERVICES	517,449.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,696,625.00	2,420.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	309,073.00	0.00
AUDIOLOGY	158,677.00	540.00
CARDIOLOGY	5,294,998.02	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	112,243.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,188,932.00	52,725.00
OTHER LAB SERVICES	248,911.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	1,936.00	4,034.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,117,941.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	12,114.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	537.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	417,328.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	198,948.00

TOTAL ANCILLARY	122,150,759.22	399,082.50
TOTAL ACCOMODATIONS	36,436,907.00	1,291,686.00
TOTAL CHARGES	158,587,666.22	1,690,768.50

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	509,906.09	ADJUSTMENTS	0.00
COVERED CHARGES	503,933.09	CONTRACTUAL ALLOW	324,656.44
NON-COVERED CHARGES	5,973.00	TOTAL MEDICAID LIAB	179,276.65
		LESS: COB	179,276.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	32	0	20,608.00	312.00
NURSERY CARE CHARGES	7	0	4,508.00	2,576.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	39	0	25,116.00	2,888.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	22	0	32,200.00	0.00
N I C U	1	0	1,596.00	0.00
PED I C U	17	0	27,132.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	40	0	60,928.00	0.00
TOTAL ACCOMODATIONS	79	0	86,044.00	2,888.00

ZERO PAID INPATIENT PAID CLAIMS

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,821.09	0.00
MED/SURG SUPPLY	95,797.00	880.00
LABORATORY-GENERAL	46,053.00	0.00
RADIOLOGY-DIAGNOSTIC	6,603.00	0.00
CT SCAN	16,442.00	0.00
PHYSICAL THERAPY	152.00	0.00
EKG/ECG	1,755.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,008.00	0.00
LABOR/DELIVERY ROOM	10,114.00	0.00
RESPIRATORY SERVICES	62,799.00	0.00
ANESTHESIA	2,842.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,985.00	0.00
RECOVERY ROOM	510.00	0.00
LABORATORY PATHOLOGIC	372.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	450.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,270.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,709.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	108.00	0.00
CARDIOLOGY	21,607.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	712.00	0.00
OTHER LAB SERVICES	521.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,259.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,205.00

TOTAL ANCILLARY	417,889.09	3,085.00
TOTAL ACCOMODATIONS	86,044.00	2,888.00
TOTAL CHARGES	503,933.09	5,973.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	46,559,028.87	ADJUSTMENTS	1,776,543.88
COVERED CHARGES	43,840,704.07	CONTRACTUAL ALLOW	28,671,360.11
NON-COVERED CHARGES	2,718,324.80	TOTAL MEDICAID LIAB	15,169,343.96
		LESS: COB	25,482.62
		LESS: COPAYMENT	68,871.00
		REIMBURSEMENT	15,074,990.34
		ALL OTHER	12,838,899.61
		FEE SCHEDULE-LAB	2,108,907.89
		INJECTABLE DRUGS	127,182.84

TOTAL NUMBER OF CLAIMS 60,357

OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,237,133.04	23,338.20
MED/SURG SUPPLY	1,548,416.75	30,130.00
LABORATORY-GENERAL	16,485.00	81,748.03
RADIOLOGY-DIAGNOSTIC	1,864,110.00	45,219.00
CT SCAN	2,528,426.00	81,052.00
PHYSICAL THERAPY	266,648.00	6,232.00
EKG/ECG	366,650.00	102.00
IV THERAPY	60,256.00	2,586.00
OPERATING ROOM	3,011,530.00	115,319.00
LABOR/DELIVERY ROOM	989,992.00	11,475.00
RESPIRATORY SERVICES	493,759.00	5,618.00
ANESTHESIA	611,979.00	61,602.00
GI SERVICES	11,018.00	0.00
EMERGENCY ROOM	4,557,002.60	6,875.00
RECOVERY ROOM	964,254.00	0.00
LABORATORY PATHOLOGIC	0.00	460.00
RADIOLOGY THERAPEUTIC	123,948.00	1,287.00
OCCUPATIONAL THERAPY	176,007.00	5,621.00
SPEECH PATHOLOGY	134,685.00	731.00
RENAL DIALYSIS	0.00	4,940.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,956,862.43	8,383.00
PSYCHIATRIC SERVICES	7,332.00	1,542.00
LITHOTRIPSY	21,252.00	0.00
OTHER IMAGING SERVICES	570,461.00	18,615.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	388,826.00	16,850.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	400,597.00	49,773.00
AUDIOLOGY	1,188.00	0.00
CARDIOLOGY	551,177.00	22,374.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	145,503.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,940,320.00	35,405.00
OTHER LAB SERVICES	135,407.00	794.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	30,216.00	16,676.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,352,961.35	1,967,970.47
MRI SERVICES	50,494.00	5,236.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,814.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	11,222.00	375.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	314,471.90	6,686.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	114.00	74,851.20

TOTAL ANCILLARY	43,840,704.07	2,717,680.80
TOTAL ACCOMODATIONS	0.00	644.00
TOTAL CHARGES	43,840,704.07	2,718,324.80

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	153,666.02	ADJUSTMENTS	0.00
COVERED CHARGES	129,888.02	CONTRACTUAL ALLOW	77,272.10
NON-COVERED CHARGES	23,778.00	TOTAL MEDICAID LIAB	52,615.92
		LESS: COB	52,420.92
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	0.00
		ALL OTHER	6,090.12-
		FEE SCHEDULE-LAB	6,090.12
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 177

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,856.40	0.00
MED/SURG SUPPLY	5,088.00	0.00
LABORATORY-GENERAL	0.00	1,793.00
RADIOLOGY-DIAGNOSTIC	5,818.00	228.00
CT SCAN	12,669.00	2,285.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	714.00	0.00
IV THERAPY	414.00	0.00
OPERATING ROOM	5,968.00	4,611.00
LABOR/DELIVERY ROOM	2,184.00	0.00
RESPIRATORY SERVICES	977.00	82.00
ANESTHESIA	2,258.00	228.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,179.00	50.00
RECOVERY ROOM	3,595.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	728.00	0.00
OCCUPATIONAL THERAPY	2,447.00	522.00
SPEECH PATHOLOGY	2,240.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,182.00	578.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,029.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	484.00	1,980.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,232.00	1,487.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,598.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,103.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,884.00	34.00
OTHER LAB SERVICES	583.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	114.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	40,657.62	9,353.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	433.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	129,888.02	23,778.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	129,888.02	23,778.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,696,184.39	ADJUSTMENTS	2,473.71
COVERED CHARGES	1,593,813.29	CONTRACTUAL ALLOW	1,496,263.29
NON-COVERED CHARGES	102,371.10	TOTAL MEDICAID LIAB	97,550.00
		LESS: COB	10.29
		LESS: COPAYMENT	2,931.00
		REIMBURSEMENT	94,608.71

TOTAL NUMBER OF CLAIMS 1,951

OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113,887.60	102.10
MED/SURG SUPPLY	23,409.00	531.00
LABORATORY-GENERAL	343,711.69	74,629.00
RADIOLOGY-DIAGNOSTIC	106,713.00	935.00
CT SCAN	85,449.00	14,514.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	18,939.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,469.00	160.00
LABOR/DELIVERY ROOM	546.00	0.00
RESPIRATORY SERVICES	54,056.00	0.00
ANESTHESIA	854.00	506.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	761,009.00	1,935.00
RECOVERY ROOM	1,020.00	0.00
LABORATORY PATHOLOGIC	95.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,512.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,427.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,932.00	484.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,576.00	246.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,314.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	848.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	34,308.00	5,454.00
OTHER LAB SERVICES	2,505.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	14,233.00	2,261.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	614.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,593,813.29	102,371.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,593,813.29	102,371.10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,369.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,142.50	CONTRACTUAL ALLOW	7,879.15
NON-COVERED CHARGES	2,227.00	TOTAL MEDICAID LIAB	1,263.35
		LESS: COB	1,251.35
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,597.50	0.00
MED/SURG SUPPLY	178.00	0.00
LABORATORY-GENERAL	2,835.00	851.00
RADIOLOGY-DIAGNOSTIC	535.00	0.00
CT SCAN	0.00	1,115.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	204.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	147.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,646.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	261.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,142.50	2,227.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,142.50	2,227.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,894,030.08	ADJUSTMENTS	332,286.50
COVERED CHARGES	10,572,109.21	CONTRACTUAL ALLOW	7,919,915.49
NON-COVERED CHARGES	321,920.87	TOTAL MEDICAID LIAB	2,652,193.72
		LESS: COB	6,131.68
		LESS: COPAYMENT	2,220.00
		REIMBURSEMENT	2,643,842.04

TOTAL NUMBER OF CLAIMS 654

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP154

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,650,052.46	1,140.60
MED/SURG SUPPLY	1,230,530.00	23,289.00
LABORATORY-GENERAL	404.00	625.00
RADIOLOGY-DIAGNOSTIC	373,884.00	58,795.00
CT SCAN	165,934.00	7,061.00
PHYSICAL THERAPY	2,230.00	0.00
EKG/ECG	71,533.00	0.00
IV THERAPY	2,960.00	0.00
OPERATING ROOM	306,445.00	8,370.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	54,793.00	146.00
ANESTHESIA	64,912.00	456.00
GI SERVICES	96.00	0.00
EMERGENCY ROOM	234,957.00	50.00
RECOVERY ROOM	72,035.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	126,890.00	1,056.00
OCCUPATIONAL THERAPY	644.00	0.00
SPEECH PATHOLOGY	452.00	0.00
RENAL DIALYSIS	0.00	7,904.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,398.00	95.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,626.00	0.00
OTHER IMAGING SERVICES	12,981.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,757.00	968.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	63,019.00	4,674.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,007,460.00	66,238.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	848.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	632,809.00	25,396.00
OTHER LAB SERVICES	37,900.00	676.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	50.00	0.00
OTHER THERAPEUTIC SERVI	1,662.00	1,108.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	373,746.75	95,870.27
MRI SERVICES	45,889.00	4,332.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	1,212.00	13,671.00

TOTAL ANCILLARY	10,572,109.21	321,920.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,572,109.21	321,920.87

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MED CTR OF CENTRAL GA
777 HEMLOCK STREET
MACON GA 31201-2102

PROVIDER NUMBER 000001207A
NUMBER OF BEDS 477
TITLE XVIII NO: HOSP154

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	113,958,081.38	ADJUSTMENTS	13,369,001.48
COVERED CHARGES	104,679,835.46	CONTRACTUAL ALLOW	48,955,650.48
NON-COVERED CHARGES	9,278,245.92	TOTAL MEDICAID LIAB	55,724,184.98
		LESS: COB	270,103.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	55,454,081.42

TOTAL NUMBER OF ADMISSIONS 5,587

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19,744	1,052	7,166,300.10	2,573,068.50
NURSERY CARE CHARGES	6,642	0	2,276,534.00	5,971,297.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	72	0.00	0.00
TOTAL ROUTINE	26,386	1,124	9,442,834.10	8,544,366.00
SPECIAL CARE SERVICES				
C C U	122	0	100,767.50	0.00
I C U	2,182	0	2,088,269.00	0.00
N I C U	2,938	0	5,389,514.00	0.00
PED I C U	1,594	0	2,924,278.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	708	0	1,147,633.00	0.00
BURN UNIT	735	0	751,301.50	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8,279	0	12,401,763.00	0.00
TOTAL ACCOMODATIONS	34,665	1,124	21,844,597.10	8,544,366.00

INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,566,392.80	0.00
MED/SURG SUPPLY	16,626,283.45	21,238.90
LABORATORY-GENERAL	10,054,146.35	13,506.50
RADIOLOGY-DIAGNOSTIC	2,473,553.00	0.00
CT SCAN	2,664,554.00	8,459.21
PHYSICAL THERAPY	575,688.70	0.00
EKG/ECG	552,681.00	0.00
IV THERAPY	328,779.38	0.00
OPERATING ROOM	2,949,282.60	0.00
LABOR/DELIVERY ROOM	1,238,572.70	0.00
RESPIRATORY SERVICES	9,657,810.68	0.00
ANESTHESIA	640,230.56	0.00
GI SERVICES	214,414.22	0.00
EMERGENCY ROOM	2,704,602.33	0.00
RECOVERY ROOM	664,999.00	0.00
LABORATORY PATHOLOGIC	951,998.00	0.00
RADIOLOGY THERAPEUTIC	43,553.35	3,935.50
OCCUPATIONAL THERAPY	165,431.00	0.00
SPEECH PATHOLOGY	131,567.00	0.00
RENAL DIALYSIS	85,715.60	1,832.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	79,345.22
PSYCHIATRIC SERVICES	5,632.50	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	744,597.00	14,884.00
BLOOD	1,233,031.00	0.00
BLOOD STORAGE & PRO.	874,580.55	22,619.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	266,689.00	0.00
AUDIOLOGY	57,530.35	10,378.00
CARDIOLOGY	971,788.81	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	655,179.85	0.00
ORGAN ACQUISITION	59,631.50	11,074.00
TREATMENT/OBSERVATION	1,094,458.19	0.00
OTHER LAB SERVICES	282,996.98	83.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	25,170.00	693.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	595,271.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	321,992.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,678,425.91	0.00
HOME HEALTH SERVICES	0.00	1,322.09
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	222,516.50

TOTAL ANCILLARY	82,835,238.36	733,879.92
TOTAL ACCOMODATIONS	21,844,597.10	8,544,366.00
TOTAL CHARGES	104,679,835.46	9,278,245.92

ZERO PAID INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,069,904.53	ADJUSTMENTS	0.00
COVERED CHARGES	1,973,831.03	CONTRACTUAL ALLOW	175,771.26
NON-COVERED CHARGES	96,073.50	TOTAL MEDICAID LIAB	1,798,059.77
		LESS: COB	1,798,059.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 90

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	420	4	152,455.50	51,463.00
NURSERY CARE CHARGES	15	0	5,445.00	17,250.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	435	4	157,900.50	68,713.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	2,055.00	0.00
N I C U	9	0	16,533.00	0.00
PED I C U	48	0	87,812.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	16	0	25,936.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	76	0	132,336.00	0.00
TOTAL ACCOMODATIONS	511	4	290,236.50	68,713.00

ZERO PAID INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	408,317.89	0.00
MED/SURG SUPPLY	359,566.80	3,278.00
LABORATORY-GENERAL	170,950.55	820.00
RADIOLOGY-DIAGNOSTIC	36,837.00	0.00
CT SCAN	51,728.50	0.00
PHYSICAL THERAPY	7,165.00	0.00
EKG/ECG	12,512.60	0.00
IV THERAPY	1,581.00	0.00
OPERATING ROOM	62,836.00	0.00
LABOR/DELIVERY ROOM	55,629.50	0.00
RESPIRATORY SERVICES	120,572.50	0.00
ANESTHESIA	16,989.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,330.50	0.00
RECOVERY ROOM	19,087.50	0.00
LABORATORY PATHOLOGIC	31,143.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,425.00	0.00
SPEECH PATHOLOGY	1,490.00	0.00
RENAL DIALYSIS	1,425.60	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,513.00
PSYCHIATRIC SERVICES	145.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,376.50	0.00
BLOOD	24,189.75	0.00
BLOOD STORAGE & PRO.	17,595.50	465.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,947.00	0.00
AUDIOLOGY	614.25	157.00
CARDIOLOGY	21,828.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,276.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,665.95	0.00
OTHER LAB SERVICES	7,833.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,217.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	13,817.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	169,316.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,310.00

TOTAL ANCILLARY	1,683,594.53	27,360.50
TOTAL ACCOMODATIONS	290,236.50	68,713.00
TOTAL CHARGES	1,973,831.03	96,073.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	40,274,830.74	ADJUSTMENTS	2,022,585.18
COVERED CHARGES	37,059,045.64	CONTRACTUAL ALLOW	16,903,827.20
NON-COVERED CHARGES	3,215,785.10	TOTAL MEDICAID LIAB	20,155,218.44
		LESS: COB	45,893.00
		LESS: COPAYMENT	69,372.00
		REIMBURSEMENT	20,039,953.44
		ALL OTHER	18,212,586.92
		FEE SCHEDULE-LAB	1,674,033.64
		INJECTABLE DRUGS	153,332.88

TOTAL NUMBER OF CLAIMS 78,247

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,072,511.62	244,917.09
MED/SURG SUPPLY	2,984,874.38	134,665.92
LABORATORY-GENERAL	74,907.50	305,441.63
RADIOLOGY-DIAGNOSTIC	1,498,762.33	47,001.00
CT SCAN	2,486,804.00	26,647.50
PHYSICAL THERAPY	434,294.80	6,943.00
EKG/ECG	295,790.90	1,787.90
IV THERAPY	307,792.73	0.00
OPERATING ROOM	2,017,411.49	207,476.15
LABOR/DELIVERY ROOM	72,737.70	5,091.00
RESPIRATORY SERVICES	424,523.70	469.00
ANESTHESIA	501,213.65	6,986.00
GI SERVICES	310,748.47	24,206.28
EMERGENCY ROOM	4,371,961.89	8,253.50
RECOVERY ROOM	1,279,527.60	20,818.00
LABORATORY PATHOLOGIC	0.00	3,090.50
RADIOLOGY THERAPEUTIC	777,259.00	156,109.00
OCCUPATIONAL THERAPY	401,135.00	10,885.00
SPEECH PATHOLOGY	246,492.00	3,052.00
RENAL DIALYSIS	0.00	458.00
OUTPATIENT SERVICES	0.00	78.00
CLINIC SERVICES	4,422,280.50	26,310.81
PSYCHIATRIC SERVICES	341,823.20	35,631.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	984,867.70	50,110.00
BLOOD	78,608.00	31,961.00
BLOOD STORAGE & PRO.	61,417.00	104,191.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	416,379.90	32,345.00
AUDIOLOGY	73,999.15	1,684.90
CARDIOLOGY	765,411.67	3,263.50
AMBULATORY SURGERY	6,422.00	0.00
OSTEOPATHIC SERVICES	0.00	605.50
E E G	212,670.50	2,451.50
ORGAN ACQUISITION	0.00	19,379.50
TREATMENT/OBSERVATION	1,170,726.49	74,038.77
OTHER LAB SERVICES	607,107.63	8,836.50
RECREATIONAL THERAPY	1,026.00	0.00
EDUCATION & TRAINING	7,392.50	0.00
OTHER THERAPEUTIC SERVI	67,067.50	2,713.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,941,301.80	1,005,930.64
MRI SERVICES	1,103,219.00	5,412.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	132.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	106.50
AMBULANCE	0.00	8,068.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	238,205.34	493,115.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	371.00	94,372.20

TOTAL ANCILLARY	37,059,045.64	3,215,038.10
TOTAL ACCOMODATIONS	0.00	747.00
TOTAL CHARGES	37,059,045.64	3,215,785.10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	851,011.92	ADJUSTMENTS	0.00
COVERED CHARGES	746,053.62	CONTRACTUAL ALLOW	62,657.36
NON-COVERED CHARGES	104,958.30	TOTAL MEDICAID LIAB	683,396.26
		LESS: COB	682,931.26
		LESS: COPAYMENT	465.00
		REIMBURSEMENT	0.00
		ALL OTHER	30,839.69-
		FEE SCHEDULE-LAB	30,588.65
		INJECTABLE DRUGS	251.04

TOTAL NUMBER OF CLAIMS 1,042

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,862.92	1,248.33
MED/SURG SUPPLY	77,769.87	2,082.50
LABORATORY-GENERAL	2,750.50	5,020.30
RADIOLOGY-DIAGNOSTIC	21,621.00	1,204.40
CT SCAN	50,674.00	0.00
PHYSICAL THERAPY	12,539.00	150.00
EKG/ECG	3,058.50	0.00
IV THERAPY	3,046.70	0.00
OPERATING ROOM	49,523.50	9,178.50
LABOR/DELIVERY ROOM	2,055.50	0.00
RESPIRATORY SERVICES	12,642.50	45.00
ANESTHESIA	16,830.80	0.00
GI SERVICES	2,246.50	0.00
EMERGENCY ROOM	56,139.00	317.00
RECOVERY ROOM	39,000.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	11,993.00	355.00
OCCUPATIONAL THERAPY	16,510.50	0.00
SPEECH PATHOLOGY	5,610.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	36,254.00	133.50
PSYCHIATRIC SERVICES	5,584.20	397.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	20,364.00	312.00
BLOOD	1,898.00	2,564.00
BLOOD STORAGE & PRO.	1,836.50	4,654.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,262.50	2,958.00
AUDIOLOGY	1,190.25	0.00
CARDIOLOGY	33,299.40	161.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,934.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,374.40	0.00
OTHER LAB SERVICES	21,230.50	73.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	115,942.88	39,124.33
MRI SERVICES	45,618.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	390.00	32,950.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,028.50

TOTAL ANCILLARY	746,053.62	104,958.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	746,053.62	104,958.30

OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,478,703.12	ADJUSTMENTS	5,271.00
COVERED CHARGES	1,456,726.76	CONTRACTUAL ALLOW	1,206,219.66
NON-COVERED CHARGES	21,976.36	TOTAL MEDICAID LIAB	250,507.10
		LESS: COB	294.15
		LESS: COPAYMENT	3,156.00
		REIMBURSEMENT	247,056.95

TOTAL NUMBER OF CLAIMS 5,010

OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,987.97	1,918.32
MED/SURG SUPPLY	14,006.49	2,892.50
LABORATORY-GENERAL	114,355.09	7,943.50
RADIOLOGY-DIAGNOSTIC	62,659.00	1,129.50
CT SCAN	107,604.50	1,326.00
PHYSICAL THERAPY	545.00	0.00
EKG/ECG	16,962.50	0.00
IV THERAPY	22,625.00	0.00
OPERATING ROOM	9,276.50	0.00
LABOR/DELIVERY ROOM	458.00	0.00
RESPIRATORY SERVICES	8,749.50	0.00
ANESTHESIA	1,915.01	371.00
GI SERVICES	1,063.50	0.00
EMERGENCY ROOM	966,791.50	1,321.00
RECOVERY ROOM	5,007.30	667.00
LABORATORY PATHOLOGIC	4,570.00	71.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	100.00	275.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,775.50	20.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,154.64	522.00
BLOOD	961.50	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,365.50	0.00
AUDIOLOGY	12.00	0.00
CARDIOLOGY	3,589.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,070.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,636.50	1,226.00
OTHER LAB SERVICES	2,539.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	72.76	36.38
MRI SERVICES	13,873.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,936.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	320.50

TOTAL ANCILLARY	1,456,726.76	21,976.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,456,726.76	21,976.36

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST

AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,711.14	ADJUSTMENTS	0.00
COVERED CHARGES	18,401.14	CONTRACTUAL ALLOW	4,553.52
NON-COVERED CHARGES	310.00	TOTAL MEDICAID LIAB	13,847.62
		LESS: COB	13,823.62
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 49

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	616.64	0.00
MED/SURG SUPPLY	15.00	0.00
LABORATORY-GENERAL	3,109.00	272.50
RADIOLOGY-DIAGNOSTIC	570.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	275.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,770.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,044.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	37.50

TOTAL ANCILLARY	18,401.14	310.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,401.14	310.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,609,955.34	ADJUSTMENTS	161,063.73
COVERED CHARGES	3,449,513.90	CONTRACTUAL ALLOW	2,107,782.24
NON-COVERED CHARGES	160,441.44	TOTAL MEDICAID LIAB	1,341,731.66
		LESS: COB	1,000.00
		LESS: COPAYMENT	378.00
		REIMBURSEMENT	1,340,353.66

TOTAL NUMBER OF CLAIMS 240

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	407,754.00	25,237.96
MED/SURG SUPPLY	1,385,067.67	1,880.00
LABORATORY-GENERAL	2,440.50	1,543.50
RADIOLOGY-DIAGNOSTIC	66,321.02	8,918.00
CT SCAN	77,439.50	2,723.50
PHYSICAL THERAPY	3,650.00	0.00
EKG/ECG	10,914.80	0.00
IV THERAPY	29,814.83	0.00
OPERATING ROOM	346,673.60	210.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,494.00	0.00
ANESTHESIA	61,186.60	492.50
GI SERVICES	0.00	0.00
EMERGENCY ROOM	77,735.00	0.00
RECOVERY ROOM	90,749.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	101,883.36	32,421.00
OCCUPATIONAL THERAPY	0.00	325.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,053.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,175.50	543.00
BLOOD	1,898.00	9,765.00
BLOOD STORAGE & PRO.	15,464.00	8,992.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,282.90	1,479.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	178,319.60	19,504.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,468.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	48,881.83	781.50
OTHER LAB SERVICES	1,253.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	55,374.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	175,311.86	8,008.87
MRI SERVICES	5,822.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	772.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	253,085.03	26,336.11
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10,508.00

TOTAL ANCILLARY	3,449,513.90	160,441.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,449,513.90	160,441.44

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	10,861.20	ADJUSTMENTS	0.00
COVERED CHARGES	10,658.70	CONTRACTUAL ALLOW	2,416.13
NON-COVERED CHARGES	202.50	TOTAL MEDICAID LIAB	8,242.57
		LESS: COB	8,242.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	761.20	0.00
MED/SURG SUPPLY	1,043.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	75.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,426.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	352.50	202.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,658.70	202.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,658.70	202.50

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

CHARGES		PAYMENTS	
TOTAL CHARGES	115,105,926.69	ADJUSTMENTS	14,545,162.54
COVERED CHARGES	104,873,939.30	CONTRACTUAL ALLOW	49,862,215.12
NON-COVERED CHARGES	10,231,987.39	TOTAL MEDICAID LIAB	55,011,724.18
		LESS: COB	318,084.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	54,693,639.95

TOTAL NUMBER OF ADMISSIONS 5,354

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,803	702	6,653,922.50	1,925,080.50
NURSERY CARE CHARGES	7,894	3	2,799,218.00	7,387,668.72
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	57	0.00	0.00
TOTAL ROUTINE	25,697	762	9,453,140.50	9,312,749.22
SPECIAL CARE SERVICES				
C C U	147	0	131,888.50	0.00
I C U	1,706	0	1,646,466.00	0.00
N I C U	2,510	0	4,626,142.00	0.00
PED I C U	1,932	0	3,486,800.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	657	0	1,066,382.50	0.00
BURN UNIT	1,040	0	1,069,620.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	7,992	0	12,027,299.00	0.00
TOTAL ACCOMODATIONS	33,689	762	21,480,439.50	9,312,749.22

INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,904,418.05	0.00
MED/SURG SUPPLY	16,184,933.86	265,931.82
LABORATORY-GENERAL	10,243,950.43	154.50
RADIOLOGY-DIAGNOSTIC	2,270,650.51	0.00
CT SCAN	2,589,087.00	0.00
PHYSICAL THERAPY	491,066.50	0.00
EKG/ECG	626,888.96	0.00
IV THERAPY	222,020.11	0.00
OPERATING ROOM	2,852,029.90	0.00
LABOR/DELIVERY ROOM	1,447,447.00	0.00
RESPIRATORY SERVICES	10,680,758.78	0.00
ANESTHESIA	604,428.50	0.00
GI SERVICES	166,277.44	0.00
EMERGENCY ROOM	3,301,335.97	0.00
RECOVERY ROOM	613,069.00	0.00
LABORATORY PATHOLOGIC	621,883.50	0.00
RADIOLOGY THERAPEUTIC	136,703.00	0.00
OCCUPATIONAL THERAPY	161,209.35	0.00
SPEECH PATHOLOGY	126,861.50	0.00
RENAL DIALYSIS	176,120.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	97,527.00
PSYCHIATRIC SERVICES	5,868.67	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	877,931.94	0.00
BLOOD	1,343,256.09	0.00
BLOOD STORAGE & PRO.	724,475.00	19,749.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	241,473.50	0.00
AUDIOLOGY	65,684.30	0.00
CARDIOLOGY	1,417,337.14	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	541,942.20	0.00
ORGAN ACQUISITION	67,139.00	5,537.00
TREATMENT/OBSERVATION	1,411,958.48	0.00
OTHER LAB SERVICES	246,816.86	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	57,891.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	605,530.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	307,648.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,365,056.26	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	222,690.35

TOTAL ANCILLARY	83,393,499.80	919,238.17
TOTAL ACCOMODATIONS	21,480,439.50	9,312,749.22
TOTAL CHARGES	104,873,939.30	10,231,987.39

ZERO PAID INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,230,398.85	ADJUSTMENTS	0.00
COVERED CHARGES	2,064,644.76	CONTRACTUAL ALLOW	34,018.22
NON-COVERED CHARGES	165,754.09	TOTAL MEDICAID LIAB	2,030,626.54
		LESS: COB	2,030,626.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 93

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	434	0	162,242.00	28,765.50
NURSERY CARE CHARGES	107	0	40,018.00	121,873.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	541	1	202,260.00	150,638.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	12	0	9,987.00	0.00
N I C U	42	0	77,154.00	0.00
PED I C U	40	0	72,832.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	94	0	159,973.00	0.00
TOTAL ACCOMODATIONS	635	1	362,233.00	150,638.50

ZERO PAID INPATIENT PAID CLAIMS

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402,600.14	0.00
MED/SURG SUPPLY	365,985.53	11,065.59
LABORATORY-GENERAL	175,763.78	0.00
RADIOLOGY-DIAGNOSTIC	26,886.00	0.00
CT SCAN	36,460.50	0.00
PHYSICAL THERAPY	15,213.00	0.00
EKG/ECG	8,509.50	0.00
IV THERAPY	2,379.10	0.00
OPERATING ROOM	79,857.50	0.00
LABOR/DELIVERY ROOM	40,218.00	0.00
RESPIRATORY SERVICES	175,058.00	0.00
ANESTHESIA	17,023.00	0.00
GI SERVICES	1,369.50	0.00
EMERGENCY ROOM	45,586.75	0.00
RECOVERY ROOM	17,886.00	0.00
LABORATORY PATHOLOGIC	12,068.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,420.00	0.00
SPEECH PATHOLOGY	250.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,838.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,021.16	0.00
BLOOD	25,895.75	0.00
BLOOD STORAGE & PRO.	24,113.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,197.00	0.00
AUDIOLOGY	640.00	0.00
CARDIOLOGY	15,074.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,224.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,619.00	0.00
OTHER LAB SERVICES	2,913.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,821.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	669.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	146,358.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	542.50

TOTAL ANCILLARY	1,702,411.76	15,115.59
TOTAL ACCOMODATIONS	362,233.00	150,638.50
TOTAL CHARGES	2,064,644.76	165,754.09

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	43,213,394.20	ADJUSTMENTS	1,031,879.42
COVERED CHARGES	39,770,466.63	CONTRACTUAL ALLOW	24,341,506.97
NON-COVERED CHARGES	3,442,927.57	TOTAL MEDICAID LIAB	15,428,959.66
		LESS: COB	22,569.86
		LESS: COPAYMENT	70,341.00
		REIMBURSEMENT	15,336,048.80
		ALL OTHER	13,380,369.85
		FEE SCHEDULE-LAB	1,955,630.79
		INJECTABLE DRUGS	48.16

TOTAL NUMBER OF CLAIMS 75,245

OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,210,614.87	7,687.24
MED/SURG SUPPLY	3,140,581.40	80,197.25
LABORATORY-GENERAL	42,846.50	298,107.67
RADIOLOGY-DIAGNOSTIC	1,466,891.85	39,402.26
CT SCAN	2,106,148.00	169,943.00
PHYSICAL THERAPY	458,083.20	3,512.00
EKG/ECG	318,408.50	235.50
IV THERAPY	300,068.84	101,083.64
OPERATING ROOM	2,331,304.26	230,552.25
LABOR/DELIVERY ROOM	95,679.00	380.00
RESPIRATORY SERVICES	513,627.44	4,919.00
ANESTHESIA	555,784.00	6,265.50
GI SERVICES	247,243.19	11,565.50
EMERGENCY ROOM	5,337,809.42	37,263.50
RECOVERY ROOM	1,364,092.00	0.00
LABORATORY PATHOLOGIC	0.00	337.00
RADIOLOGY THERAPEUTIC	845,434.36	269,348.00
OCCUPATIONAL THERAPY	412,781.15	12,100.00
SPEECH PATHOLOGY	281,003.00	5,445.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,206,989.38	17,660.18
PSYCHIATRIC SERVICES	314,776.62	17,453.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,037,795.55	101,412.14
BLOOD	105,085.25	48,579.50
BLOOD STORAGE & PRO.	68,721.00	139,950.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	370,796.00	19,890.00
AUDIOLOGY	90,651.35	1,431.00
CARDIOLOGY	990,246.16	73,710.00
AMBULATORY SURGERY	7,588.50	0.00
OSTEOPATHIC SERVICES	0.00	1,572.55
E E G	159,632.55	0.00
ORGAN ACQUISITION	0.00	22,148.00
TREATMENT/OBSERVATION	1,571,666.89	37,384.22
OTHER LAB SERVICES	521,634.33	7,199.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,499.00	250.00
OTHER THERAPEUTIC SERVI	35,310.00	448.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,173,940.80	832,831.53
MRI SERVICES	1,083,610.50	44,543.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	27,525.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	121.77	549,009.64
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	218,756.00

TOTAL ANCILLARY	39,770,466.63	3,440,098.57
TOTAL ACCOMODATIONS	0.00	2,829.00
TOTAL CHARGES	39,770,466.63	3,442,927.57

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	812,890.71	ADJUSTMENTS	0.00
COVERED CHARGES	722,473.96	CONTRACTUAL ALLOW	79,439.34
NON-COVERED CHARGES	90,416.75	TOTAL MEDICAID LIAB	643,034.62
		LESS: COB	642,554.62
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	0.00
		ALL OTHER	43,482.56-
		FEE SCHEDULE-LAB	43,458.48
		INJECTABLE DRUGS	24.08

TOTAL NUMBER OF CLAIMS 927

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,067.41	510.01
MED/SURG SUPPLY	71,085.45	1,213.50
LABORATORY-GENERAL	1,232.00	3,185.50
RADIOLOGY-DIAGNOSTIC	28,053.00	445.00
CT SCAN	19,608.00	1,644.00
PHYSICAL THERAPY	9,568.50	0.00
EKG/ECG	4,369.50	0.00
IV THERAPY	4,128.50	808.50
OPERATING ROOM	65,316.00	16,927.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,972.61	135.00
ANESTHESIA	20,167.50	0.00
GI SERVICES	1,726.00	0.00
EMERGENCY ROOM	69,810.79	190.00
RECOVERY ROOM	52,087.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,011.50	557.00
OCCUPATIONAL THERAPY	9,070.50	450.00
SPEECH PATHOLOGY	4,945.00	142.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	33,991.50	257.00
PSYCHIATRIC SERVICES	4,014.05	132.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,730.94	1,291.11
BLOOD	641.00	961.50
BLOOD STORAGE & PRO.	1,794.50	2,492.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,106.00	0.00
AUDIOLOGY	1,009.65	0.00
CARDIOLOGY	17,377.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,990.05	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,454.54	55.50
OTHER LAB SERVICES	15,954.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	492.00	2,583.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	141,547.12	6,566.65
MRI SERVICES	27,110.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40.59	46,556.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,312.50

TOTAL ANCILLARY	722,473.96	90,416.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	722,473.96	90,416.75

OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,097,384.57	ADJUSTMENTS	5,430.00
COVERED CHARGES	2,037,484.53	CONTRACTUAL ALLOW	1,738,598.28
NON-COVERED CHARGES	59,900.04	TOTAL MEDICAID LIAB	298,886.25
		LESS: COB	474.85
		LESS: COPAYMENT	5,442.00
		REIMBURSEMENT	292,969.40

TOTAL NUMBER OF CLAIMS 5,961

OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,974.31	478.46
MED/SURG SUPPLY	16,792.05	0.00
LABORATORY-GENERAL	191,278.42	10,150.65
RADIOLOGY-DIAGNOSTIC	79,102.00	950.50
CT SCAN	115,352.00	3,494.00
PHYSICAL THERAPY	150.00	0.00
EKG/ECG	17,726.50	0.00
IV THERAPY	18,179.70	18,706.20
OPERATING ROOM	12,426.42	0.00
LABOR/DELIVERY ROOM	916.00	0.00
RESPIRATORY SERVICES	11,390.00	135.00
ANESTHESIA	2,429.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,393,529.29	10,241.00
RECOVERY ROOM	6,045.50	0.00
LABORATORY PATHOLOGIC	2,039.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	150.00	0.00
SPEECH PATHOLOGY	335.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,123.50	68.50
PSYCHIATRIC SERVICES	84.00	105.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,865.04	1,091.00
BLOOD	1,211.00	2,970.00
BLOOD STORAGE & PRO.	0.00	1,005.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,551.50	0.00
AUDIOLOGY	607.25	0.00
CARDIOLOGY	4,805.34	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	463.05	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,278.00	785.00
OTHER LAB SERVICES	3,065.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	2,517.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,942.64	1,638.39
MRI SERVICES	18,155.00	1,328.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,122.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,256.50

TOTAL ANCILLARY	2,037,484.53	59,526.54
TOTAL ACCOMODATIONS	0.00	373.50
TOTAL CHARGES	2,037,484.53	59,900.04

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST

AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	30,806.33	ADJUSTMENTS	0.00
COVERED CHARGES	29,256.93	CONTRACTUAL ALLOW	8,798.11
NON-COVERED CHARGES	1,549.40	TOTAL MEDICAID LIAB	20,458.82
		LESS: COB	20,419.82
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 70

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,114.56	0.00
MED/SURG SUPPLY	3.00	0.00
LABORATORY-GENERAL	3,297.87	182.00
RADIOLOGY-DIAGNOSTIC	1,422.50	214.50
CT SCAN	1,966.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	240.00	0.00
IV THERAPY	119.00	132.90
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	55.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,952.00	1,020.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	121.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	693.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	416.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,855.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	29,256.93	1,549.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,256.93	1,549.40

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,241,672.95	ADJUSTMENTS	110,325.50
COVERED CHARGES	3,954,811.42	CONTRACTUAL ALLOW	3,141,037.55
NON-COVERED CHARGES	286,861.53	TOTAL MEDICAID LIAB	813,773.87
		LESS: COB	0.00
		LESS: COPAYMENT	858.00
		REIMBURSEMENT	812,915.87

TOTAL NUMBER OF CLAIMS 168

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	300,922.58	716.44
MED/SURG SUPPLY	1,821,063.56	159,417.00
LABORATORY-GENERAL	1,935.00	94.00
RADIOLOGY-DIAGNOSTIC	107,790.27	15,565.76
CT SCAN	28,061.00	2,600.50
PHYSICAL THERAPY	2,275.00	0.00
EKG/ECG	6,731.00	298.00
IV THERAPY	7,192.38	1,572.10
OPERATING ROOM	248,128.50	8,602.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	775.50	104.50
ANESTHESIA	42,398.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	44,702.00	2,268.00
RECOVERY ROOM	62,276.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	107,827.00	611.50
OCCUPATIONAL THERAPY	175.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	458.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,923.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,090.50	0.00
BLOOD	11,960.00	0.00
BLOOD STORAGE & PRO.	2,898.00	4,870.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,311.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	177,739.50	47,992.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,308.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	188,691.00	1,105.50
OTHER LAB SERVICES	498.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	27.50	0.00
OTHER THERAPEUTIC SERVI	2,517.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	766,007.63	9,552.32
MRI SERVICES	4,586.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	28,114.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,918.50

TOTAL ANCILLARY	3,954,811.42	286,861.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,954,811.42	286,861.53

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
TITLE XVIII NO: 1992986293

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	45,639.43	ADJUSTMENTS	0.00
COVERED CHARGES	45,369.43	CONTRACTUAL ALLOW	18,174.93
NON-COVERED CHARGES	270.00	TOTAL MEDICAID LIAB	27,194.50
		LESS: COB	27,149.50
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MCG HEALTH INC
1120 15TH ST
AUGUSTA GA 30912-0004

PROVIDER NUMBER 000000723A
NUMBER OF BEDS 457
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 1992986293

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,956.61	0.00
MED/SURG SUPPLY	6,794.82	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	174.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,755.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	686.50	45.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	12,490.50	225.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,502.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,580.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,430.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	45,369.43	270.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,369.43	270.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,573,287.95	ADJUSTMENTS	40,768.28
COVERED CHARGES	2,561,032.45	CONTRACTUAL ALLOW	753,876.54
NON-COVERED CHARGES	12,255.50	TOTAL MEDICAID LIAB	1,807,155.91
		LESS: COB	14,106.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,793,049.38

TOTAL NUMBER OF ADMISSIONS 580

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,133	0	371,240.00	11,800.00
NURSERY CARE CHARGES	337	0	69,085.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,470	0	440,325.00	11,800.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	63	0	50,085.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	63	0	50,085.00	0.00
TOTAL ACCOMODATIONS	1,533	0	490,410.00	11,800.00

INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	567,765.15	0.00
MED/SURG SUPPLY	338,580.04	0.00
LABORATORY-GENERAL	252,612.98	215.30
RADIOLOGY-DIAGNOSTIC	43,543.70	0.00
CT SCAN	110,224.74	0.00
PHYSICAL THERAPY	10,772.84	0.00
EKG/ECG	17,279.06	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	142,649.50	0.00
LABOR/DELIVERY ROOM	114,325.25	0.00
RESPIRATORY SERVICES	87,564.42	0.00
ANESTHESIA	134,955.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	65,858.68	0.00
RECOVERY ROOM	51,367.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	34,976.98	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,376.52	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,166.30	0.00
AUDIOLOGY	6,675.00	0.00
CARDIOLOGY	12,503.49	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,318.90	0.00
OTHER LAB SERVICES	41,052.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,034.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,020.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	240.20

TOTAL ANCILLARY	2,070,622.45	455.50
TOTAL ACCOMODATIONS	490,410.00	11,800.00
TOTAL CHARGES	2,561,032.45	12,255.50

ZERO PAID INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21,186.96	ADJUSTMENTS	0.00
COVERED CHARGES	21,066.96	CONTRACTUAL ALLOW	7,188.40
NON-COVERED CHARGES	120.00	TOTAL MEDICAID LIAB	13,878.56
		LESS: COB	13,878.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6	0	1,980.00	120.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	1,980.00	120.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	795.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	795.00	0.00
TOTAL ACCOMODATIONS	7	0	2,775.00	120.00

ZERO PAID INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,864.50	0.00
MED/SURG SUPPLY	3,201.75	0.00
LABORATORY-GENERAL	2,220.81	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,687.50	0.00
LABOR/DELIVERY ROOM	3,588.80	0.00
RESPIRATORY SERVICES	75.90	0.00
ANESTHESIA	2,337.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	177.00	0.00
RECOVERY ROOM	675.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	568.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	895.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,291.96	0.00
TOTAL ACCOMODATIONS	2,775.00	120.00
TOTAL CHARGES	21,066.96	120.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,329,000.19	ADJUSTMENTS	24,882.96
COVERED CHARGES	2,195,631.18	CONTRACTUAL ALLOW	1,416,457.97
NON-COVERED CHARGES	133,369.01	TOTAL MEDICAID LIAB	779,173.21
		LESS: COB	1,142.71
		LESS: COPAYMENT	2,673.00
		REIMBURSEMENT	775,357.50
		ALL OTHER	712,742.48
		FEE SCHEDULE-LAB	61,361.24
		INJECTABLE DRUGS	1,253.78

TOTAL NUMBER OF CLAIMS 3,923

OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,729.29	16,776.25
MED/SURG SUPPLY	141,583.15	3,877.20
LABORATORY-GENERAL	543.20	18,108.21
RADIOLOGY-DIAGNOSTIC	192,476.79	6,398.58
CT SCAN	204,554.76	2,629.00
PHYSICAL THERAPY	32,838.39	0.00
EKG/ECG	25,761.52	153.00
IV THERAPY	0.00	0.00
OPERATING ROOM	156,614.40	17,369.00
LABOR/DELIVERY ROOM	18,213.20	0.00
RESPIRATORY SERVICES	14,086.27	201.50
ANESTHESIA	72,717.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	403,176.17	3,705.28
RECOVERY ROOM	57,461.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	810.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	187,083.75	493.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	617.04
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,388.25	6,440.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,217.99	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,754.85	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	56,961.35	641.50
OTHER LAB SERVICES	55,169.20	2,247.80
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	364,693.70	45,871.90
MRI SERVICES	29,661.10	6,882.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,135.25	957.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,195,631.18	133,369.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,195,631.18	133,369.01

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21,343.53	ADJUSTMENTS	0.00
COVERED CHARGES	18,584.42	CONTRACTUAL ALLOW	11,146.17
NON-COVERED CHARGES	2,759.11	TOTAL MEDICAID LIAB	7,438.25
		LESS: COB	7,432.25
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,279.96-
		FEE SCHEDULE-LAB	1,279.96
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	779.75	0.00
MED/SURG SUPPLY	389.95	0.00
LABORATORY-GENERAL	0.00	750.69
RADIOLOGY-DIAGNOSTIC	1,245.10	0.00
CT SCAN	812.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	306.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,920.30	275.92
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	71.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,913.10	568.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	192.85	0.00
OTHER LAB SERVICES	338.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,686.77	1,093.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,584.42	2,759.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,584.42	2,759.11

OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	253,244.52	ADJUSTMENTS	591.00
COVERED CHARGES	249,854.78	CONTRACTUAL ALLOW	208,185.42
NON-COVERED CHARGES	3,389.74	TOTAL MEDICAID LIAB	41,669.36
		LESS: COB	126.26
		LESS: COPAYMENT	516.00
		REIMBURSEMENT	41,027.10

TOTAL NUMBER OF CLAIMS 841

OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,527.59	0.00
MED/SURG SUPPLY	5,208.40	0.00
LABORATORY-GENERAL	39,978.84	3,327.58
RADIOLOGY-DIAGNOSTIC	21,235.00	0.00
CT SCAN	10,170.49	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,696.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	3,473.70	0.00
RESPIRATORY SERVICES	582.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,998.76	62.16
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,079.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	10,604.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	249,854.78	3,389.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	249,854.78	3,389.74

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,014.13	ADJUSTMENTS	0.00
COVERED CHARGES	2,380.47	CONTRACTUAL ALLOW	983.96
NON-COVERED CHARGES	633.66	TOTAL MEDICAID LIAB	1,396.51
		LESS: COB	1,396.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	497.50	300.00
MED/SURG SUPPLY	14.25	0.00
LABORATORY-GENERAL	845.50	160.20
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	153.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	870.22	100.56
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	29.90
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	43.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,380.47	633.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,380.47	633.66

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,623.47	ADJUSTMENTS	0.00
COVERED CHARGES	12,605.47	CONTRACTUAL ALLOW	8,508.13
NON-COVERED CHARGES	18.00	TOTAL MEDICAID LIAB	4,097.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,097.34

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	954.00	0.00
MED/SURG SUPPLY	3,048.42	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	425.00	0.00
CT SCAN	4,015.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,700.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,100.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	283.00	0.00
RECOVERY ROOM	600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	135.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	345.05	18.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,605.47	18.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,605.47	18.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,065,339.91	ADJUSTMENTS	10,954.17
COVERED CHARGES	3,053,511.61	CONTRACTUAL ALLOW	1,221,389.31
NON-COVERED CHARGES	11,828.30	TOTAL MEDICAID LIAB	1,832,122.30
		LESS: COB	5,615.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,826,506.83

TOTAL NUMBER OF ADMISSIONS 567

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,107	0	361,350.00	10,340.00
NURSERY CARE CHARGES	328	0	67,240.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,435	0	428,590.00	10,340.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	91	0	72,345.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	91	0	72,345.00	0.00
TOTAL ACCOMODATIONS	1,526	0	500,935.00	10,340.00

INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	605,965.20	0.00
MED/SURG SUPPLY	415,123.65	0.00
LABORATORY-GENERAL	391,976.37	82.30
RADIOLOGY-DIAGNOSTIC	51,279.29	0.00
CT SCAN	114,395.85	0.00
PHYSICAL THERAPY	7,890.50	0.00
EKG/ECG	23,015.26	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	172,428.90	0.00
LABOR/DELIVERY ROOM	159,847.50	0.00
RESPIRATORY SERVICES	134,964.03	0.00
ANESTHESIA	131,968.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	106,751.80	0.00
RECOVERY ROOM	62,319.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	202.50	0.00
SPEECH PATHOLOGY	208.55	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	55,031.96	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,656.26	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,173.56	0.00
AUDIOLOGY	11,770.00	0.00
CARDIOLOGY	17,692.83	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,610.00	0.00
OTHER LAB SERVICES	38,237.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,066.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,406.00

TOTAL ANCILLARY	2,552,576.61	1,488.30
TOTAL ACCOMODATIONS	500,935.00	10,340.00
TOTAL CHARGES	3,053,511.61	11,828.30

ZERO PAID INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,341.22	ADJUSTMENTS	0.00
COVERED CHARGES	4,341.22	CONTRACTUAL ALLOW	983.49
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,357.73
		LESS: COB	3,357.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	660.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	660.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	660.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,405.50	0.00
MED/SURG SUPPLY	599.30	0.00
LABORATORY-GENERAL	528.02	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,148.40	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,681.22	0.00
TOTAL ACCOMODATIONS	660.00	0.00
TOTAL CHARGES	4,341.22	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,704,363.48	ADJUSTMENTS	15,771.04
COVERED CHARGES	2,499,907.57	CONTRACTUAL ALLOW	1,800,903.39
NON-COVERED CHARGES	204,455.91	TOTAL MEDICAID LIAB	699,004.18
		LESS: COB	277.99
		LESS: COPAYMENT	2,088.00
		REIMBURSEMENT	696,638.19
		ALL OTHER	626,002.52
		FEE SCHEDULE-LAB	70,635.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,597

OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,652.34	10,188.75
MED/SURG SUPPLY	125,863.25	3,454.20
LABORATORY-GENERAL	575.20	26,057.54
RADIOLOGY-DIAGNOSTIC	221,715.13	3,786.32
CT SCAN	194,975.22	9,093.80
PHYSICAL THERAPY	35,982.98	0.00
EKG/ECG	26,614.66	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	80,507.60	3,825.00
LABOR/DELIVERY ROOM	10,581.25	0.00
RESPIRATORY SERVICES	21,989.97	0.00
ANESTHESIA	50,310.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	533,723.70	37,604.60
RECOVERY ROOM	31,337.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	607.50	1,485.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	203,098.74	4,395.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,251.44
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,105.50	3,548.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,610.86	3,781.98
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,351.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	73,311.65	92.80
OTHER LAB SERVICES	75,260.20	677.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	571,611.74	76,808.36
MRI SERVICES	83,121.08	5,806.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	541.97
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	8,746.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,309.60

TOTAL ANCILLARY	2,499,907.57	204,455.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,499,907.57	204,455.91

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,395.92	ADJUSTMENTS	0.00
COVERED CHARGES	17,272.69	CONTRACTUAL ALLOW	8,729.51
NON-COVERED CHARGES	2,123.23	TOTAL MEDICAID LIAB	8,543.18
		LESS: COB	8,540.18
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,066.67-
		FEE SCHEDULE-LAB	1,066.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	469.75	0.00
MED/SURG SUPPLY	462.40	0.00
LABORATORY-GENERAL	0.00	879.58
RADIOLOGY-DIAGNOSTIC	571.10	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,302.90	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	189.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,825.80	287.70
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	987.01	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	677.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,787.13	955.95
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,272.69	2,123.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,272.69	2,123.23

OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	264,708.53	ADJUSTMENTS	191.00
COVERED CHARGES	255,836.77	CONTRACTUAL ALLOW	222,786.77
NON-COVERED CHARGES	8,871.76	TOTAL MEDICAID LIAB	33,050.00
		LESS: COB	81.36
		LESS: COPAYMENT	528.00
		REIMBURSEMENT	32,440.64

TOTAL NUMBER OF CLAIMS 666

OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,060.63	4.25
MED/SURG SUPPLY	9,306.70	0.00
LABORATORY-GENERAL	51,110.01	2,821.17
RADIOLOGY-DIAGNOSTIC	12,865.68	121.69
CT SCAN	2,332.60	1,166.30
PHYSICAL THERAPY	757.70	0.00
EKG/ECG	1,721.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,250.00	0.00
LABOR/DELIVERY ROOM	2,719.00	0.00
RESPIRATORY SERVICES	2,302.40	0.00
ANESTHESIA	1,575.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	129,799.20	4,676.60
RECOVERY ROOM	675.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,389.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,767.05	0.00
OTHER LAB SERVICES	13,205.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	66.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	15.00

TOTAL ANCILLARY	255,836.77	8,871.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	255,836.77	8,871.76

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,275.39	ADJUSTMENTS	0.00
COVERED CHARGES	1,426.89	CONTRACTUAL ALLOW	501.14
NON-COVERED CHARGES	848.50	TOTAL MEDICAID LIAB	925.75
		LESS: COB	922.75
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	585.75	504.00
MED/SURG SUPPLY	43.00	0.00
LABORATORY-GENERAL	267.64	28.10
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	530.50	316.40
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,426.89	848.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,426.89	848.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHMONT OF GA
DBA MEMORIAL HOSPITAL ADEL INC
706 N PARRISH AVE
ADEL GA 31620-1511

PROVIDER NUMBER 000001251A
NUMBER OF BEDS 60
TITLE XVIII NO: HPH0081GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,041,515.43	ADJUSTMENTS	15,899.07
COVERED CHARGES	3,981,597.83	CONTRACTUAL ALLOW	1,437,833.94
NON-COVERED CHARGES	59,917.60	TOTAL MEDICAID LIAB	2,543,763.89
		LESS: COB	27,436.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,516,327.62

TOTAL NUMBER OF ADMISSIONS 966

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,909	0	694,828.00	40,849.00
NURSERY CARE CHARGES	638	0	208,350.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,547	0	903,178.00	40,849.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	127	0	98,050.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	127	0	98,050.00	0.00
TOTAL ACCOMODATIONS	2,674	0	1,001,228.00	40,849.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	638,288.58	0.00
MED/SURG SUPPLY	547,784.00	0.00
LABORATORY-GENERAL	493,878.00	0.00
RADIOLOGY-DIAGNOSTIC	56,185.00	0.00
CT SCAN	49,429.00	0.00
PHYSICAL THERAPY	20,886.00	0.00
EKG/ECG	26,723.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	376,408.50	0.00
LABOR/DELIVERY ROOM	356,122.00	0.00
RESPIRATORY SERVICES	143,237.00	0.00
ANESTHESIA	14,457.85	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,363.00	0.00
RECOVERY ROOM	20,178.50	0.00
LABORATORY PATHOLOGIC	11,231.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,540.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,963.60
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,838.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,251.00	15,105.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,638.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	55,793.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,677.00	0.00
OTHER LAB SERVICES	1,961.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,226.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	93,274.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,980,369.83	19,068.60
TOTAL ACCOMODATIONS	1,001,228.00	40,849.00
TOTAL CHARGES	3,981,597.83	59,917.60

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,473,645.62	ADJUSTMENTS	49,301.19
COVERED CHARGES	3,248,445.34	CONTRACTUAL ALLOW	1,843,036.26
NON-COVERED CHARGES	225,200.28	TOTAL MEDICAID LIAB	1,405,409.08
		LESS: COB	6,489.65
		LESS: COPAYMENT	7,275.00
		REIMBURSEMENT	1,391,644.43
		ALL OTHER	1,250,862.55
		FEE SCHEDULE-LAB	132,666.99
		INJECTABLE DRUGS	8,114.89

TOTAL NUMBER OF CLAIMS 7,575

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,021.86	21,106.87
MED/SURG SUPPLY	184,615.00	2,364.00
LABORATORY-GENERAL	833.00	18,371.00
RADIOLOGY-DIAGNOSTIC	252,909.00	3,516.00
CT SCAN	151,978.00	2,176.00
PHYSICAL THERAPY	141,272.00	10,772.00
EKG/ECG	41,766.00	1,105.00
IV THERAPY	0.00	0.00
OPERATING ROOM	379,057.00	9,668.00
LABOR/DELIVERY ROOM	82,880.00	0.00
RESPIRATORY SERVICES	23,011.00	299.00
ANESTHESIA	12,597.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	493,780.00	7,936.00
RECOVERY ROOM	30,959.00	173.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	31,174.00	1,726.00
SPEECH PATHOLOGY	1,215.00	63.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	46,508.00	572.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,601.00	2,985.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,956.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,836.00	1,394.00
AMBULATORY SURGERY	2,348.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,720.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	183,111.00	5,489.00
OTHER LAB SERVICES	11,693.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	282.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	725,055.80	107,887.20
MRI SERVICES	133,169.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	45.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,097.68	27,291.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	261.00

TOTAL ANCILLARY	3,248,445.34	225,200.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,248,445.34	225,200.28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	15,241.80	ADJUSTMENTS	0.00
COVERED CHARGES	13,761.95	CONTRACTUAL ALLOW	8,665.55
NON-COVERED CHARGES	1,479.85	TOTAL MEDICAID LIAB	5,096.40
		LESS: COB	5,066.40
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	902.86-
		FEE SCHEDULE-LAB	881.61
		INJECTABLE DRUGS	21.25

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	505.55	115.75
MED/SURG SUPPLY	800.00	0.00
LABORATORY-GENERAL	0.00	155.00
RADIOLOGY-DIAGNOSTIC	721.00	74.00
CT SCAN	1,183.00	480.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	344.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	729.00	0.00
LABOR/DELIVERY ROOM	686.00	0.00
RESPIRATORY SERVICES	61.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,037.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	118.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	747.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,768.60	606.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	61.80	48.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,761.95	1,479.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,761.95	1,479.85

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	97,904.94	ADJUSTMENTS	494.00
COVERED CHARGES	94,052.79	CONTRACTUAL ALLOW	67,682.79
NON-COVERED CHARGES	3,852.15	TOTAL MEDICAID LIAB	26,370.00
		LESS: COB	40.75
		LESS: COPAYMENT	420.00
		REIMBURSEMENT	25,909.25

TOTAL NUMBER OF CLAIMS 548

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,466.55	0.00
MED/SURG SUPPLY	1,057.00	0.00
LABORATORY-GENERAL	15,886.00	582.00
RADIOLOGY-DIAGNOSTIC	4,935.00	0.00
CT SCAN	1,635.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	363.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	110.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	62,668.00	971.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	91.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,841.24	2,299.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	94,052.79	3,852.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,052.79	3,852.15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,666.20	ADJUSTMENTS	0.00
COVERED CHARGES	1,538.20	CONTRACTUAL ALLOW	1,169.05
NON-COVERED CHARGES	128.00	TOTAL MEDICAID LIAB	369.15
		LESS: COB	369.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202.75	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	531.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	768.00	114.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.45	14.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,538.20	128.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,538.20	128.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	37,748.50	ADJUSTMENTS	0.00
COVERED CHARGES	36,657.70	CONTRACTUAL ALLOW	24,994.66
NON-COVERED CHARGES	1,090.80	TOTAL MEDICAID LIAB	11,663.04
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	11,654.04

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,332.45	1,054.60
MED/SURG SUPPLY	18,809.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,244.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	439.00	0.00
ANESTHESIA	783.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	603.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	105.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	52.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	152.00	36.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	36,657.70	1,090.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,657.70	1,090.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,958,498.56	ADJUSTMENTS	26,042.06
COVERED CHARGES	3,916,937.96	CONTRACTUAL ALLOW	1,494,191.75
NON-COVERED CHARGES	41,560.60	TOTAL MEDICAID LIAB	2,422,746.21
		LESS: COB	14,228.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,408,517.58

TOTAL NUMBER OF ADMISSIONS 889

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,800	0	691,931.00	31,436.00
NURSERY CARE CHARGES	541	0	183,582.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,341	0	875,513.00	31,436.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	94	0	73,655.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	94	0	73,655.00	0.00
TOTAL ACCOMODATIONS	2,435	0	949,168.00	31,436.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	639,938.91	0.00
MED/SURG SUPPLY	513,559.05	0.00
LABORATORY-GENERAL	527,066.00	0.00
RADIOLOGY-DIAGNOSTIC	55,996.00	0.00
CT SCAN	63,499.00	0.00
PHYSICAL THERAPY	19,751.00	0.00
EKG/ECG	33,136.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	328,265.00	0.00
LABOR/DELIVERY ROOM	363,508.00	0.00
RESPIRATORY SERVICES	128,991.00	0.00
ANESTHESIA	18,463.95	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,639.00	0.00
RECOVERY ROOM	17,142.00	0.00
LABORATORY PATHOLOGIC	10,593.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,857.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,655.60
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,994.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,257.00	5,917.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,506.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	56,616.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,390.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,418.00	552.00
OTHER LAB SERVICES	2,921.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,205.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	127,058.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,967,769.96	10,124.60
TOTAL ACCOMODATIONS	949,168.00	31,436.00
TOTAL CHARGES	3,916,937.96	41,560.60

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,613,848.10	ADJUSTMENTS	4,421.70
COVERED CHARGES	3,394,339.26	CONTRACTUAL ALLOW	2,197,592.39
NON-COVERED CHARGES	219,508.84	TOTAL MEDICAID LIAB	1,196,746.87
		LESS: COB	1,984.37
		LESS: COPAYMENT	5,556.00
		REIMBURSEMENT	1,189,206.50
		ALL OTHER	1,024,231.33
		FEE SCHEDULE-LAB	147,332.48
		INJECTABLE DRUGS	17,642.69

TOTAL NUMBER OF CLAIMS 7,545

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	196,977.42	1,101.90
MED/SURG SUPPLY	168,227.40	186.00
LABORATORY-GENERAL	476.00	29,989.00
RADIOLOGY-DIAGNOSTIC	258,948.00	1,441.00
CT SCAN	171,835.00	23,646.00
PHYSICAL THERAPY	193,484.00	1,953.00
EKG/ECG	41,636.00	36.00
IV THERAPY	0.00	0.00
OPERATING ROOM	321,927.50	12,978.00
LABOR/DELIVERY ROOM	82,907.00	0.00
RESPIRATORY SERVICES	16,047.00	57.00
ANESTHESIA	14,057.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	527,441.00	6,950.00
RECOVERY ROOM	24,051.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	51,707.00	0.00
SPEECH PATHOLOGY	733.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	72,828.00	2,590.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,689.00	5,555.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,118.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	62,510.00	0.00
AMBULATORY SURGERY	2,898.00	174.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	22,925.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	173,455.00	7,798.00
OTHER LAB SERVICES	6,020.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	140.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	812,283.50	115,771.50
MRI SERVICES	117,789.00	8,934.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	71.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,228.74	277.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,394,339.26	219,508.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,394,339.26	219,508.84

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,123.40	ADJUSTMENTS	0.00
COVERED CHARGES	6,545.40	CONTRACTUAL ALLOW	1,813.60
NON-COVERED CHARGES	1,578.00	TOTAL MEDICAID LIAB	4,731.80
		LESS: COB	4,728.80
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	351.95-
		FEE SCHEDULE-LAB	347.23
		INJECTABLE DRUGS	4.72

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	528.40	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	97.00
RADIOLOGY-DIAGNOSTIC	541.00	0.00
CT SCAN	1,373.00	1,442.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	860.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,994.00	39.00
MRI SERVICES	1,236.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,545.40	1,578.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,545.40	1,578.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	125,814.52	ADJUSTMENTS	114.00
COVERED CHARGES	123,771.52	CONTRACTUAL ALLOW	96,728.52
NON-COVERED CHARGES	2,043.00	TOTAL MEDICAID LIAB	27,043.00
		LESS: COB	9.00
		LESS: COPAYMENT	684.00
		REIMBURSEMENT	26,350.00

TOTAL NUMBER OF CLAIMS 598

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,955.65	246.00
MED/SURG SUPPLY	1,715.00	0.00
LABORATORY-GENERAL	29,048.00	1,663.00
RADIOLOGY-DIAGNOSTIC	5,167.00	0.00
CT SCAN	1,465.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,251.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	257.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	71,494.00	134.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	791.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	62.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,565.87	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	123,771.52	2,043.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,771.52	2,043.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,507.20	ADJUSTMENTS	0.00
COVERED CHARGES	6,258.20	CONTRACTUAL ALLOW	6,258.20
NON-COVERED CHARGES	1,249.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,216.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	1,699.00	16.00
RADIOLOGY-DIAGNOSTIC	574.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	154.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,484.00	1,233.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	131.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,258.20	1,249.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,258.20	1,249.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,521.95	ADJUSTMENTS	0.00
COVERED CHARGES	11,521.95	CONTRACTUAL ALLOW	7,634.27
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,887.68
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,884.68

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,516.95	0.00
MED/SURG SUPPLY	5,215.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,467.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	141.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	182.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,521.95	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,521.95	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	3,385,592.32	ADJUSTMENTS	19,000.18
COVERED CHARGES	3,336,950.72	CONTRACTUAL ALLOW	1,557,742.79
NON-COVERED CHARGES	48,641.60	TOTAL MEDICAID LIAB	1,779,207.93
		LESS: COB	12,001.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,767,206.76

TOTAL NUMBER OF ADMISSIONS 564

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,457	0	607,555.00	33,255.00
NURSERY CARE CHARGES	331	0	118,134.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,788	0	725,689.00	33,255.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	83	0	70,310.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	83	0	70,310.00	0.00
TOTAL ACCOMODATIONS	1,871	0	795,999.00	33,255.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	532,121.57	0.00
MED/SURG SUPPLY	430,626.46	498.00
LABORATORY-GENERAL	445,738.00	0.00
RADIOLOGY-DIAGNOSTIC	47,574.00	0.00
CT SCAN	97,790.00	0.00
PHYSICAL THERAPY	22,923.88	0.00
EKG/ECG	27,768.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	247,326.00	0.00
LABOR/DELIVERY ROOM	214,113.00	0.00
RESPIRATORY SERVICES	126,902.00	0.00
ANESTHESIA	13,752.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,430.00	0.00
RECOVERY ROOM	12,461.00	0.00
LABORATORY PATHOLOGIC	6,342.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,905.00	0.00
SPEECH PATHOLOGY	1,710.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,474.60
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,092.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,094.00	11,039.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,266.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,435.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,390.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,014.00	68.00
OTHER LAB SERVICES	4,478.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	14,464.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	202,235.61	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	307.00

TOTAL ANCILLARY	2,540,951.72	15,386.60
TOTAL ACCOMODATIONS	795,999.00	33,255.00
TOTAL CHARGES	3,336,950.72	48,641.60

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	4,120.34	ADJUSTMENTS	0.00
COVERED CHARGES	3,980.34	CONTRACTUAL ALLOW	701.09
NON-COVERED CHARGES	140.00	TOTAL MEDICAID LIAB	3,279.25
		LESS: COB	3,279.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	780.00	140.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	780.00	140.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	780.00	140.00

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268.34	0.00
MED/SURG SUPPLY	254.00	0.00
LABORATORY-GENERAL	214.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,168.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	262.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	34.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,200.34	0.00
TOTAL ACCOMODATIONS	780.00	140.00
TOTAL CHARGES	3,980.34	140.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	2,649,417.75	ADJUSTMENTS	13,117.29
COVERED CHARGES	2,450,107.55	CONTRACTUAL ALLOW	1,662,713.08
NON-COVERED CHARGES	199,310.20	TOTAL MEDICAID LIAB	787,394.47
		LESS: COB	371.12
		LESS: COPAYMENT	4,389.00
		REIMBURSEMENT	782,634.35
		ALL OTHER	660,079.31
		FEE SCHEDULE-LAB	111,686.79
		INJECTABLE DRUGS	10,868.25

TOTAL NUMBER OF CLAIMS 4,820

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,752.60	12,877.50
MED/SURG SUPPLY	115,383.60	873.00
LABORATORY-GENERAL	0.00	31,876.00
RADIOLOGY-DIAGNOSTIC	166,474.00	1,752.00
CT SCAN	176,857.00	32,841.00
PHYSICAL THERAPY	122,486.00	1,611.00
EKG/ECG	25,478.00	690.00
IV THERAPY	0.00	0.00
OPERATING ROOM	206,769.00	4,036.00
LABOR/DELIVERY ROOM	45,246.00	0.00
RESPIRATORY SERVICES	11,908.00	205.00
ANESTHESIA	9,139.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	383,212.00	488.00
RECOVERY ROOM	14,351.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	41,682.00	0.00
SPEECH PATHOLOGY	183.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	72.00	136.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	52,304.00	1,497.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	735.00	4,430.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,436.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	40,672.00	0.00
AMBULATORY SURGERY	998.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	28,065.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	67,182.00	6,460.00
OTHER LAB SERVICES	4,530.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	694,288.70	91,961.30
MRI SERVICES	93,533.00	7,378.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28,370.50	198.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,450,107.55	199,310.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,450,107.55	199,310.20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	14,549.30	ADJUSTMENTS	0.00
COVERED CHARGES	11,865.30	CONTRACTUAL ALLOW	5,650.98
NON-COVERED CHARGES	2,684.00	TOTAL MEDICAID LIAB	6,214.32
		LESS: COB	6,214.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	509.99-
		FEE SCHEDULE-LAB	498.22
		INJECTABLE DRUGS	11.77

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213.00	494.00
MED/SURG SUPPLY	448.00	0.00
LABORATORY-GENERAL	0.00	87.00
RADIOLOGY-DIAGNOSTIC	1,017.00	0.00
CT SCAN	3,457.00	1,902.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	102.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	376.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,558.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	131.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	68.00	0.00
OTHER LAB SERVICES	411.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,054.00	201.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,865.30	2,684.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,865.30	2,684.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	132,106.40	ADJUSTMENTS	347.00
COVERED CHARGES	129,683.65	CONTRACTUAL ALLOW	106,636.65
NON-COVERED CHARGES	2,422.75	TOTAL MEDICAID LIAB	23,047.00
		LESS: COB	0.00
		LESS: COPAYMENT	477.00
		REIMBURSEMENT	22,570.00

TOTAL NUMBER OF CLAIMS 469

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,512.95	342.75
MED/SURG SUPPLY	2,025.00	0.00
LABORATORY-GENERAL	28,425.00	1,267.00
RADIOLOGY-DIAGNOSTIC	4,879.00	0.00
CT SCAN	4,129.00	813.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,142.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	357.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	75,827.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,022.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	66.00	0.00
OTHER LAB SERVICES	411.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,887.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	129,683.65	2,422.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	129,683.65	2,422.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	2,379.45	ADJUSTMENTS	0.00
COVERED CHARGES	2,158.45	CONTRACTUAL ALLOW	1,974.45
NON-COVERED CHARGES	221.00	TOTAL MEDICAID LIAB	184.00
		LESS: COB	181.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP114

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172.45	0.00
MED/SURG SUPPLY	13.00	0.00
LABORATORY-GENERAL	949.00	155.00
RADIOLOGY-DIAGNOSTIC	213.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	102.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	695.00	66.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,158.45	221.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,158.45	221.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL
1500 E SHOTWELL ST
BAINBRIDGE GA 39819-4256

PROVIDER NUMBER 000001262A
NUMBER OF BEDS 80
TITLE XVIII NO: HOSP114

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	131,044,676.49	ADJUSTMENTS	4,945,317.06
COVERED CHARGES	119,262,229.89	CONTRACTUAL ALLOW	65,558,908.02
NON-COVERED CHARGES	11,782,446.60	TOTAL MEDICAID LIAB	53,703,321.87
		LESS: COB	319,354.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	53,383,967.11

TOTAL NUMBER OF ADMISSIONS 6,772

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19,828	0	9,792,488.00	3,070,657.50
NURSERY CARE CHARGES	8,956	0	3,895,807.00	5,972,121.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	181	0.00	181.00
TOTAL ROUTINE	28,784	181	13,688,295.00	9,042,959.50
SPECIAL CARE SERVICES				
C C U	227	0	390,849.00	0.00
I C U	3,311	0	5,288,675.00	0.00
N I C U	3,332	0	7,080,500.00	0.00
PED I C U	1,029	0	2,840,103.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	1,024	0.00	698,098.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	7,899	1,024	15,600,127.00	698,098.00
TOTAL ACCOMODATIONS	36,683	1,205	29,288,422.00	9,741,057.50

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,247,739.98	0.00
MED/SURG SUPPLY	17,376,878.12	126,910.88
LABORATORY-GENERAL	9,857,247.41	1,214.31
RADIOLOGY-DIAGNOSTIC	3,287,448.44	0.00
CT SCAN	2,554,920.18	32,225.94
PHYSICAL THERAPY	818,945.82	0.00
EKG/ECG	376,755.67	0.00
IV THERAPY	133,724.36	0.00
OPERATING ROOM	14,794,893.77	0.00
LABOR/DELIVERY ROOM	4,558,307.22	43,273.86
RESPIRATORY SERVICES	4,335,140.28	0.00
ANESTHESIA	6,976.54	0.00
GI SERVICES	245,849.27	0.00
EMERGENCY ROOM	2,092,597.19	0.00
RECOVERY ROOM	2,255,047.75	0.00
LABORATORY PATHOLOGIC	421,134.53	0.00
RADIOLOGY THERAPEUTIC	111,614.16	0.00
OCCUPATIONAL THERAPY	624,957.80	0.00
SPEECH PATHOLOGY	267,171.31	0.00
RENAL DIALYSIS	407,672.12	1,298.76
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	11,107.08
PSYCHIATRIC SERVICES	12,831.83	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	967,546.79	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,380,013.53	3,998.11
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	194,001.11	0.00
AUDIOLOGY	2,051.96	212.57
CARDIOLOGY	869,635.70	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	213,553.72	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	335,811.02	0.00
OTHER LAB SERVICES	284,019.51	0.00
RECREATIONAL THERAPY	15,212.46	0.00
EDUCATION & TRAINING	5,271.15	3,400.00
OTHER THERAPEUTIC SERVI	0.00	37.04
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	726,834.95	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	8,395.45	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	644,360.03
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	20,589.59
INJECTABLE DRUGS	5,183,606.79	1,085,191.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	485.90
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	67,083.05

TOTAL ANCILLARY	89,973,807.89	2,041,389.10
TOTAL ACCOMODATIONS	29,288,422.00	9,741,057.50
TOTAL CHARGES	119,262,229.89	11,782,446.60

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	529,560.13	ADJUSTMENTS	0.00
COVERED CHARGES	490,116.47	CONTRACTUAL ALLOW	36,711.07
NON-COVERED CHARGES	39,443.66	TOTAL MEDICAID LIAB	453,405.40
		LESS: COB	453,405.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	24	0	11,944.00	10,177.00
NURSERY CARE CHARGES	16	0	8,096.00	21,904.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	40	0	20,040.00	32,081.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	8	0	15,240.00	0.00
N I C U	82	0	174,250.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	90	0	189,490.00	0.00
TOTAL ACCOMODATIONS	130	0	209,530.00	32,081.00

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,834.47	0.00
MED/SURG SUPPLY	42,925.13	0.00
LABORATORY-GENERAL	54,500.60	0.00
RADIOLOGY-DIAGNOSTIC	9,724.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,159.12	0.00
LABOR/DELIVERY ROOM	18,392.77	0.00
RESPIRATORY SERVICES	72,515.42	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,722.06	0.00
RECOVERY ROOM	1,232.89	0.00
LABORATORY PATHOLOGIC	2,341.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	618.27	0.00
SPEECH PATHOLOGY	311.85	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,433.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,008.71	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	770.78	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	970.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,128.21
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,123.60	4,234.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	280,586.47	7,362.66
TOTAL ACCOMODATIONS	209,530.00	32,081.00
TOTAL CHARGES	490,116.47	39,443.66

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	44,699,467.88	ADJUSTMENTS	526,410.23
COVERED CHARGES	40,289,632.83	CONTRACTUAL ALLOW	18,634,554.76
NON-COVERED CHARGES	4,409,835.05	TOTAL MEDICAID LIAB	21,655,078.07
		LESS: COB	95,591.84
		LESS: COPAYMENT	43,566.00
		REIMBURSEMENT	21,515,920.23
		ALL OTHER	20,587,740.18
		FEE SCHEDULE-LAB	726,527.81
		INJECTABLE DRUGS	201,652.24

TOTAL NUMBER OF CLAIMS 44,680

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	995,415.42	41,395.14
MED/SURG SUPPLY	2,661,820.74	155,981.00
LABORATORY-GENERAL	0.00	217,927.10
RADIOLOGY-DIAGNOSTIC	2,110,749.13	43,715.73
CT SCAN	3,364,913.46	114,526.62
PHYSICAL THERAPY	1,455,818.57	83,862.45
EKG/ECG	236,673.60	1,779.14
IV THERAPY	297,544.41	3,912.68
OPERATING ROOM	5,578,013.41	370,065.40
LABOR/DELIVERY ROOM	40,244.50	1,685.25
RESPIRATORY SERVICES	232,381.22	24,380.21
ANESTHESIA	21,495.95	0.00
GI SERVICES	185,837.73	14,765.31
EMERGENCY ROOM	6,994,515.83	11,067.11
RECOVERY ROOM	1,256,351.61	6,441.70
LABORATORY PATHOLOGIC	0.00	1,147.85
RADIOLOGY THERAPEUTIC	792,056.71	67,636.34
OCCUPATIONAL THERAPY	1,132,177.21	76,391.75
SPEECH PATHOLOGY	1,229,096.02	84,428.97
RENAL DIALYSIS	0.00	11,741.02
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	495,797.45	8,040.40
PSYCHIATRIC SERVICES	2,115.98	2,897.51
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	906,428.21	45,718.32
BLOOD	1,436.48	0.00
BLOOD STORAGE & PRO.	296,422.98	78,565.42
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	331,052.43	2,145.18
AUDIOLOGY	388.50	23.93
CARDIOLOGY	361,659.41	54,013.11
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	78,061.27	539.31
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,977,625.72	52,210.78
OTHER LAB SERVICES	375,363.44	8,526.30
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	35,415.99	9,581.32
OTHER THERAPEUTIC SERVI	0.00	6,849.82
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,790,854.56	900,045.72
MRI SERVICES	1,017,959.14	17,632.95

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,378.99	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	36,915.52
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,917.46
INJECTABLE DRUGS	1,032,379.65	1,822,336.36
HOME HEALTH SERVICES	0.00	1,140.10
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	271.20
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	187.11	22,833.57

TOTAL ANCILLARY	40,289,632.83	4,406,055.05
TOTAL ACCOMODATIONS	0.00	3,780.00
TOTAL CHARGES	40,289,632.83	4,409,835.05

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	196,412.84	ADJUSTMENTS	0.00
COVERED CHARGES	79,992.97	CONTRACTUAL ALLOW	45,909.19
NON-COVERED CHARGES	116,419.87	TOTAL MEDICAID LIAB	34,083.78
		LESS: COB	33,909.78
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,813.32-
		FEE SCHEDULE-LAB	2,035.08
		INJECTABLE DRUGS	778.24

TOTAL NUMBER OF CLAIMS 140

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,669.20	473.95
MED/SURG SUPPLY	4,650.86	0.00
LABORATORY-GENERAL	0.00	505.50
RADIOLOGY-DIAGNOSTIC	2,497.41	330.92
CT SCAN	1,129.50	0.00
PHYSICAL THERAPY	5,402.52	1,246.97
EKG/ECG	259.66	0.00
IV THERAPY	421.59	0.00
OPERATING ROOM	7,609.52	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,791.03	23,190.34
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	351.59
EMERGENCY ROOM	6,985.84	0.00
RECOVERY ROOM	2,032.33	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,220.58	1,652.81
OCCUPATIONAL THERAPY	5,312.32	0.00
SPEECH PATHOLOGY	6,040.33	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,314.35	105.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,023.24	7,435.66
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,807.02	1,224.20
ONCOLOGY	0.50	0.00
NUCLEAR MEDICINE	1,330.79	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,037.16	306.48
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	195.49	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,456.03	2,081.65
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,805.70	76,628.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	886.75

TOTAL ANCILLARY	79,992.97	116,419.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,992.97	116,419.87

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,602,870.83	ADJUSTMENTS	2,017.00
COVERED CHARGES	1,530,618.30	CONTRACTUAL ALLOW	1,382,499.71
NON-COVERED CHARGES	72,252.53	TOTAL MEDICAID LIAB	148,118.59
		LESS: COB	40.96
		LESS: COPAYMENT	2,259.00
		REIMBURSEMENT	145,818.63

TOTAL NUMBER OF CLAIMS 2,961

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,859.96	117.00
MED/SURG SUPPLY	72,500.21	3,800.80
LABORATORY-GENERAL	157,913.21	19,311.04
RADIOLOGY-DIAGNOSTIC	109,792.85	1,640.23
CT SCAN	145,553.00	2,266.70
PHYSICAL THERAPY	4,004.69	0.00
EKG/ECG	9,996.91	0.00
IV THERAPY	12,176.15	0.00
OPERATING ROOM	32,189.73	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,095.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	851,794.09	321.49
RECOVERY ROOM	6,877.75	0.00
LABORATORY PATHOLOGIC	776.51	99.20
RADIOLOGY THERAPEUTIC	1,615.10	0.00
OCCUPATIONAL THERAPY	2,727.51	0.00
SPEECH PATHOLOGY	3,367.98	0.00
RENAL DIALYSIS	0.00	1,508.03
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	517.85	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	16,213.11	394.01
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,344.08	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,374.65	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	539.31	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,110.74	0.00
OTHER LAB SERVICES	10,502.57	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	300.96	0.00
OTHER THERAPEUTIC SERVI	0.00	74.08
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	380.60	0.00
MRI SERVICES	16,585.71	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,508.07	42,714.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	5.65
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,530,618.30	72,252.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,530,618.30	72,252.53

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	15,805.79	ADJUSTMENTS	0.00
COVERED CHARGES	8,694.21	CONTRACTUAL ALLOW	7,572.39
NON-COVERED CHARGES	7,111.58	TOTAL MEDICAID LIAB	1,121.82
		LESS: COB	1,100.82
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	823.30	392.10
MED/SURG SUPPLY	265.16	168.62
LABORATORY-GENERAL	1,025.22	343.57
RADIOLOGY-DIAGNOSTIC	1,666.61	210.36
CT SCAN	0.00	1,463.16
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	129.83
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	73.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,562.66	2,887.74
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	561.33	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	657.93	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	1,198.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	58.50	318.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,694.21	7,111.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,694.21	7,111.58

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,721,437.17	ADJUSTMENTS	129,969.08
COVERED CHARGES	11,274,265.09	CONTRACTUAL ALLOW	7,524,088.99
NON-COVERED CHARGES	447,172.08	TOTAL MEDICAID LIAB	3,750,176.10
		LESS: COB	8,083.80
		LESS: COPAYMENT	1,110.00
		REIMBURSEMENT	3,740,982.30

TOTAL NUMBER OF CLAIMS 640

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	341,909.62	24,968.30
MED/SURG SUPPLY	3,537,457.93	11,405.99
LABORATORY-GENERAL	0.00	2,115.06
RADIOLOGY-DIAGNOSTIC	253,440.39	22,868.52
CT SCAN	122,714.82	6,269.16
PHYSICAL THERAPY	27,112.54	1,107.58
EKG/ECG	21,094.95	0.00
IV THERAPY	11,919.15	2,355.97
OPERATING ROOM	4,322,889.46	96,729.82
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,493.74	0.00
ANESTHESIA	704.56	0.00
GI SERVICES	79.46	0.00
EMERGENCY ROOM	51,233.09	141.04
RECOVERY ROOM	689,906.40	1,302.22
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	764,124.31	92,238.93
OCCUPATIONAL THERAPY	603.66	0.00
SPEECH PATHOLOGY	431.16	0.00
RENAL DIALYSIS	0.00	2,764.22
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,794.80	287.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	101,580.57	0.00
OTHER IMAGING SERVICES	11,236.22	1,709.99
BLOOD	89.78	0.00
BLOOD STORAGE & PRO.	90,068.22	8,174.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,879.65	715.06
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,574.17	21,949.05
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	72,847.56	0.00
OTHER LAB SERVICES	5,200.41	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	104.57	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	162,778.41	30,990.99
MRI SERVICES	34,172.88	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	220.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	499.20
INJECTABLE DRUGS	584,602.61	109,648.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	16.95
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,913.18

TOTAL ANCILLARY	11,274,265.09	447,172.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,274,265.09	447,172.08

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	133,258,004.27	ADJUSTMENTS	4,489,298.99
COVERED CHARGES	122,970,511.64	CONTRACTUAL ALLOW	68,581,210.66
NON-COVERED CHARGES	10,287,492.63	TOTAL MEDICAID LIAB	54,389,300.98
		LESS: COB	258,485.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	54,130,815.76

TOTAL NUMBER OF ADMISSIONS 7,057

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19,244	3	9,737,464.00	3,242,364.50
NURSERY CARE CHARGES	8,561	0	3,753,549.00	5,598,832.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	214	0.00	4,815.52
TOTAL ROUTINE	27,805	217	13,491,013.00	8,846,012.02
SPECIAL CARE SERVICES				
C C U	322	0	613,410.00	0.00
I C U	3,819	0	6,149,287.00	0.00
N I C U	2,891	0	6,143,375.00	0.00
PED I C U	1,162	0	3,172,885.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	16	0	29,763.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	729	0.00	496,726.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8,210	729	16,108,720.00	496,726.00
TOTAL ACCOMODATIONS	36,015	946	29,599,733.00	9,342,738.02

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,806,051.39	0.00
MED/SURG SUPPLY	19,287,099.71	53,862.69
LABORATORY-GENERAL	9,983,710.81	448.57
RADIOLOGY-DIAGNOSTIC	3,576,640.62	0.00
CT SCAN	3,302,651.01	0.00
PHYSICAL THERAPY	746,150.01	0.00
EKG/ECG	422,690.45	0.00
IV THERAPY	287,222.31	0.00
OPERATING ROOM	15,651,252.93	0.00
LABOR/DELIVERY ROOM	3,269,332.63	51,717.54
RESPIRATORY SERVICES	4,791,502.59	0.00
ANESTHESIA	3,823.15	0.00
GI SERVICES	184,677.83	0.00
EMERGENCY ROOM	2,296,767.29	0.00
RECOVERY ROOM	2,211,791.63	0.00
LABORATORY PATHOLOGIC	467,303.68	0.00
RADIOLOGY THERAPEUTIC	146,297.71	0.00
OCCUPATIONAL THERAPY	581,579.90	0.00
SPEECH PATHOLOGY	244,720.49	0.00
RENAL DIALYSIS	375,697.14	3,723.01
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10,839.62
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	14,511.51	0.00
OTHER IMAGING SERVICES	981,683.89	7,967.83
BLOOD	88,838.35	0.00
BLOOD STORAGE & PRO.	2,878,969.85	7,524.59
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	201,908.79	0.00
AUDIOLOGY	2,504.51	0.00
CARDIOLOGY	752,330.47	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	159,453.90	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	315,430.51	0.00
OTHER LAB SERVICES	404,120.73	0.00
RECREATIONAL THERAPY	16,159.38	0.00
EDUCATION & TRAINING	18,076.24	0.00
OTHER THERAPEUTIC SERVI	0.00	1,121.43
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	815,300.91	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	10,010.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	647,974.11
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	10,093.76
INJECTABLE DRUGS	5,074,516.32	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	875.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	148,605.71

TOTAL ANCILLARY	93,370,778.64	944,754.61
TOTAL ACCOMODATIONS	29,599,733.00	9,342,738.02
TOTAL CHARGES	122,970,511.64	10,287,492.63

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	615,143.94	ADJUSTMENTS	0.00
COVERED CHARGES	519,584.50	CONTRACTUAL ALLOW	17,802.22-
NON-COVERED CHARGES	95,559.44	TOTAL MEDICAID LIAB	537,386.72
		LESS: COB	537,386.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	68	0	34,408.00	19,492.75
NURSERY CARE CHARGES	64	0	31,298.00	63,418.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	132	0	65,706.00	82,910.75
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	10	0	19,050.00	0.00
N I C U	18	0	38,250.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	28	0	57,300.00	0.00
TOTAL ACCOMODATIONS	160	0	123,006.00	82,910.75

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,229.30	0.00
MED/SURG SUPPLY	39,165.00	0.00
LABORATORY-GENERAL	41,521.80	0.00
RADIOLOGY-DIAGNOSTIC	6,650.77	0.00
CT SCAN	1,463.16	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	129.83	0.00
IV THERAPY	884.47	0.00
OPERATING ROOM	41,616.07	0.00
LABOR/DELIVERY ROOM	8,354.67	0.00
RESPIRATORY SERVICES	12,213.24	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,298.94	0.00
RECOVERY ROOM	7,784.08	0.00
LABORATORY PATHOLOGIC	3,508.49	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	584.15	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,090.68	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,478.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	12,648.69
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	104,605.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	396,578.50	12,648.69
TOTAL ACCOMODATIONS	123,006.00	82,910.75
TOTAL CHARGES	519,584.50	95,559.44

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	46,665,505.45	ADJUSTMENTS	1,291,947.64
COVERED CHARGES	42,270,789.29	CONTRACTUAL ALLOW	23,291,406.20
NON-COVERED CHARGES	4,394,716.16	TOTAL MEDICAID LIAB	18,979,383.09
		LESS: COB	54,318.94
		LESS: COPAYMENT	27,105.00
		REIMBURSEMENT	18,897,959.15
		ALL OTHER	17,664,438.92
		FEE SCHEDULE-LAB	1,091,538.43
		INJECTABLE DRUGS	141,981.80

TOTAL NUMBER OF CLAIMS 44,228

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,128,987.66	18,130.18
MED/SURG SUPPLY	2,820,347.58	119,738.83
LABORATORY-GENERAL	2,869.48	487,114.94
RADIOLOGY-DIAGNOSTIC	2,232,197.34	30,739.75
CT SCAN	3,380,347.93	145,044.62
PHYSICAL THERAPY	1,376,662.93	12,426.26
EKG/ECG	221,482.52	0.00
IV THERAPY	509,379.61	6,829.94
OPERATING ROOM	6,284,703.50	459,070.80
LABOR/DELIVERY ROOM	22,283.29	2,982.89
RESPIRATORY SERVICES	238,503.13	8,065.43
ANESTHESIA	4,273.44	0.00
GI SERVICES	128,517.18	9,110.19
EMERGENCY ROOM	7,010,488.81	8,152.30
RECOVERY ROOM	1,303,724.84	3,158.05
LABORATORY PATHOLOGIC	0.00	1,157.54
RADIOLOGY THERAPEUTIC	882,932.92	13,655.01
OCCUPATIONAL THERAPY	1,131,299.89	26,106.37
SPEECH PATHOLOGY	1,081,620.35	13,420.61
RENAL DIALYSIS	0.00	4,855.11
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	469,044.37	2,249.05
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	894,248.54	19,723.73
BLOOD	2,449.70	0.00
BLOOD STORAGE & PRO.	349,388.69	115,207.03
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	282,915.09	0.00
AUDIOLOGY	0.00	23.93
CARDIOLOGY	309,485.73	56,518.66
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	279.08
E E G	87,284.97	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,938,652.44	25,823.89
OTHER LAB SERVICES	439,524.77	3,157.68
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	22,801.77	3,064.43
OTHER THERAPEUTIC SERVI	0.00	7,788.32
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,842,382.08	1,061,867.71
MRI SERVICES	1,582,681.94	33,518.98

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,295.96	110.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	82,577.46
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	392.55
INJECTABLE DRUGS	284,010.84	1,564,193.57
HOME HEALTH SERVICES	0.00	67.43
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	276.85
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42,426.99

TOTAL ANCILLARY	42,270,789.29	4,389,026.16
TOTAL ACCOMODATIONS	0.00	5,690.00
TOTAL CHARGES	42,270,789.29	4,394,716.16

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	176,682.08	ADJUSTMENTS	0.00
COVERED CHARGES	143,920.78	CONTRACTUAL ALLOW	70,466.18
NON-COVERED CHARGES	32,761.30	TOTAL MEDICAID LIAB	73,454.60
		LESS: COB	73,349.60
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	0.00
		ALL OTHER	4,174.05-
		FEE SCHEDULE-LAB	4,039.74
		INJECTABLE DRUGS	134.31

TOTAL NUMBER OF CLAIMS 168

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,041.00	84.25
MED/SURG SUPPLY	4,979.09	723.17
LABORATORY-GENERAL	0.00	1,421.75
RADIOLOGY-DIAGNOSTIC	7,213.04	0.00
CT SCAN	7,254.40	0.00
PHYSICAL THERAPY	19,380.68	2,010.64
EKG/ECG	778.98	0.00
IV THERAPY	421.59	0.00
OPERATING ROOM	5,993.31	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	838.31
EMERGENCY ROOM	17,195.01	0.00
RECOVERY ROOM	801.29	0.00
LABORATORY PATHOLOGIC	0.00	153.14
RADIOLOGY THERAPEUTIC	1,533.82	0.00
OCCUPATIONAL THERAPY	16,835.27	2,392.52
SPEECH PATHOLOGY	10,384.84	1,662.31
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	870.98	207.67
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,942.49	8,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,942.16	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,795.98	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,798.90	37.04
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	107.39	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,259.03	3,597.48
MRI SERVICES	6,041.93	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	270.60	9,359.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,773.50

TOTAL ANCILLARY	143,920.78	32,761.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	143,920.78	32,761.30

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,369,519.40	ADJUSTMENTS	9,928.99
COVERED CHARGES	1,341,194.16	CONTRACTUAL ALLOW	1,189,322.94
NON-COVERED CHARGES	28,325.24	TOTAL MEDICAID LIAB	151,871.22
		LESS: COB	63.90
		LESS: COPAYMENT	2,361.00
		REIMBURSEMENT	149,446.32

TOTAL NUMBER OF CLAIMS 2,937

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,476.65	0.00
MED/SURG SUPPLY	50,042.99	2,780.93
LABORATORY-GENERAL	172,522.59	10,294.82
RADIOLOGY-DIAGNOSTIC	83,766.34	711.83
CT SCAN	65,635.27	0.00
PHYSICAL THERAPY	396.33	0.00
EKG/ECG	9,217.93	0.00
IV THERAPY	16,639.77	421.59
OPERATING ROOM	33,390.32	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,896.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	800,462.24	239.55
RECOVERY ROOM	7,424.30	0.00
LABORATORY PATHOLOGIC	839.63	70.90
RADIOLOGY THERAPEUTIC	1,814.71	0.00
OCCUPATIONAL THERAPY	54.60	0.00
SPEECH PATHOLOGY	374.22	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	529.24	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,030.12	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,596.90	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,914.47	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,857.86	0.00
OTHER LAB SERVICES	6,640.57	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	165.96	61.39
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,362.75	4,881.55
MRI SERVICES	3,150.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,992.40	8,862.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,341,194.16	28,325.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,341,194.16	28,325.24

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,328.79	ADJUSTMENTS	0.00
COVERED CHARGES	9,140.23	CONTRACTUAL ALLOW	6,083.49
NON-COVERED CHARGES	188.56	TOTAL MEDICAID LIAB	3,056.74
		LESS: COB	3,044.74
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205.35	0.00
MED/SURG SUPPLY	195.52	0.00
LABORATORY-GENERAL	1,017.26	188.56
RADIOLOGY-DIAGNOSTIC	583.95	0.00
CT SCAN	2,926.32	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	389.49	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,772.34	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	50.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,140.23	188.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,140.23	188.56

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE

SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,251,308.11	ADJUSTMENTS	254,900.18
COVERED CHARGES	7,822,716.55	CONTRACTUAL ALLOW	5,364,628.57
NON-COVERED CHARGES	428,591.56	TOTAL MEDICAID LIAB	2,458,087.98
		LESS: COB	0.00
		LESS: COPAYMENT	1,959.00
		REIMBURSEMENT	2,456,128.98

TOTAL NUMBER OF CLAIMS 441

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,439.15	11,227.14
MED/SURG SUPPLY	2,197,553.36	695.81
LABORATORY-GENERAL	0.00	2,358.41
RADIOLOGY-DIAGNOSTIC	131,692.35	26,983.41
CT SCAN	88,453.35	1,195.43
PHYSICAL THERAPY	4,151.03	201.69
EKG/ECG	10,227.71	0.00
IV THERAPY	62,674.03	4,279.34
OPERATING ROOM	2,448,455.55	130,506.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,035.60	142.17
ANESTHESIA	528.42	0.00
GI SERVICES	1,792.07	0.00
EMERGENCY ROOM	30,324.76	0.00
RECOVERY ROOM	449,706.97	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	813,261.58	52,860.66
OCCUPATIONAL THERAPY	270.33	0.00
SPEECH PATHOLOGY	805.38	0.00
RENAL DIALYSIS	0.00	2,175.87
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,398.33	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	145,636.54	0.00
OTHER IMAGING SERVICES	13,222.53	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,472.80	4,847.06
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,774.11	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,243.23	6,606.03
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,078.62	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,127.77	0.00
OTHER LAB SERVICES	4,243.34	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,042,921.13	31,428.79
MRI SERVICES	31,858.31	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	607.10
INJECTABLE DRUGS	23,368.20	152,470.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	5.65
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,822,716.55	428,591.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,822,716.55	428,591.56

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	123,348,093.80	ADJUSTMENTS	5,607,242.28
COVERED CHARGES	114,468,202.90	CONTRACTUAL ALLOW	65,532,841.12
NON-COVERED CHARGES	8,879,890.90	TOTAL MEDICAID LIAB	48,935,361.78
		LESS: COB	265,166.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	48,670,194.87

TOTAL NUMBER OF ADMISSIONS 5,807

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,291	0	8,748,908.25	2,809,237.25
NURSERY CARE CHARGES	7,053	0	3,121,405.00	4,832,161.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	193	0.00	97,172.15
TOTAL ROUTINE	24,344	193	11,870,313.25	7,738,570.40
SPECIAL CARE SERVICES				
C C U	194	0	369,570.00	0.00
I C U	3,439	0	5,320,514.00	0.00
N I C U	3,128	0	6,647,000.00	0.00
PED I C U	1,098	0	3,020,069.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	491	0	933,443.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	13	0.00	12,285.00
REHAB	0	595	0.00	406,215.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8,350	608	16,290,596.00	418,500.00
TOTAL ACCOMODATIONS	32,694	801	28,160,909.25	8,157,070.40

INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,833,944.21	370.43
MED/SURG SUPPLY	16,507,792.02	30,950.66
LABORATORY-GENERAL	9,224,048.80	731.38
RADIOLOGY-DIAGNOSTIC	2,770,660.98	0.00
CT SCAN	3,799,908.51	0.00
PHYSICAL THERAPY	747,016.20	0.00
EKG/ECG	337,536.67	0.00
IV THERAPY	276,952.53	0.00
OPERATING ROOM	13,539,005.77	0.00
LABOR/DELIVERY ROOM	2,422,367.94	52,069.36
RESPIRATORY SERVICES	5,574,784.50	0.00
ANESTHESIA	1,431.80	0.00
GI SERVICES	168,840.24	0.00
EMERGENCY ROOM	1,658,144.88	0.00
RECOVERY ROOM	1,861,297.26	0.00
LABORATORY PATHOLOGIC	449,106.57	0.00
RADIOLOGY THERAPEUTIC	89,343.51	0.00
OCCUPATIONAL THERAPY	578,666.99	0.00
SPEECH PATHOLOGY	222,485.72	0.00
RENAL DIALYSIS	387,280.24	44.88
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	9,932.03
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	14,511.51	0.00
OTHER IMAGING SERVICES	1,018,347.16	0.00
BLOOD	225,489.77	0.00
BLOOD STORAGE & PRO.	2,775,494.74	6,318.81
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	182,065.61	0.00
AUDIOLOGY	855.75	119.00
CARDIOLOGY	729,130.24	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	138,581.43	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	265,369.67	0.00
OTHER LAB SERVICES	365,454.07	0.00
RECREATIONAL THERAPY	23,505.69	0.00
EDUCATION & TRAINING	17,147.71	0.00
OTHER THERAPEUTIC SERVI	2,835.45	1,397.65
SPECIAL CHARGES	455,440.16	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,000,659.61	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	38.26
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	10,450.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	222,803.64
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	113,012.67
INJECTABLE DRUGS	5,631,339.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	581.95
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	284,449.78

TOTAL ANCILLARY	86,307,293.65	722,820.50
TOTAL ACCOMODATIONS	28,160,909.25	8,157,070.40
TOTAL CHARGES	114,468,202.90	8,879,890.90

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	59,008.86	ADJUSTMENTS	0.00
COVERED CHARGES	51,340.13	CONTRACTUAL ALLOW	3,801.25
NON-COVERED CHARGES	7,668.73	TOTAL MEDICAID LIAB	47,538.88
		LESS: COB	47,538.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8	0	4,048.00	296.00
NURSERY CARE CHARGES	5	0	2,530.00	6,845.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	6,578.00	7,141.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	7	0	9,567.00	0.00
N I C U	1	0	2,125.00	0.00
PED I C U	1	0	2,858.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	14,550.00	0.00
TOTAL ACCOMODATIONS	22	0	21,128.00	7,141.00

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,206.35	0.00
MED/SURG SUPPLY	3,176.23	0.00
LABORATORY-GENERAL	3,222.24	0.00
RADIOLOGY-DIAGNOSTIC	370.43	0.00
CT SCAN	1,463.16	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,426.79	0.00
LABOR/DELIVERY ROOM	2,982.89	527.73
RESPIRATORY SERVICES	869.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,298.94	0.00
RECOVERY ROOM	1,087.79	0.00
LABORATORY PATHOLOGIC	141.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,874.21	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	226.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	531.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,334.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,212.13	527.73
TOTAL ACCOMODATIONS	21,128.00	7,141.00
TOTAL CHARGES	51,340.13	7,668.73

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	39,288,108.00	ADJUSTMENTS	1,844,775.83
COVERED CHARGES	36,089,919.68	CONTRACTUAL ALLOW	24,292,022.95
NON-COVERED CHARGES	3,198,188.32	TOTAL MEDICAID LIAB	11,797,896.73
		LESS: COB	13,883.10
		LESS: COPAYMENT	26,439.00
		REIMBURSEMENT	11,757,574.63
		ALL OTHER	10,615,993.56
		FEE SCHEDULE-LAB	1,062,714.10
		INJECTABLE DRUGS	78,866.97

TOTAL NUMBER OF CLAIMS 34,842

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,322,903.64	1,312.39
MED/SURG SUPPLY	2,731,669.21	69,612.88
LABORATORY-GENERAL	22,246.55	404,466.11
RADIOLOGY-DIAGNOSTIC	1,628,723.12	29,009.56
CT SCAN	2,899,192.65	197,831.01
PHYSICAL THERAPY	946,949.07	12,458.58
EKG/ECG	192,853.77	0.00
IV THERAPY	189,187.00	49,881.19
OPERATING ROOM	5,600,645.54	722,304.67
LABOR/DELIVERY ROOM	207,901.68	0.00
RESPIRATORY SERVICES	157,513.29	2,725.95
ANESTHESIA	3,195.00	0.00
GI SERVICES	144,049.92	7,997.61
EMERGENCY ROOM	5,323,292.09	5,159.68
RECOVERY ROOM	1,191,304.17	0.00
LABORATORY PATHOLOGIC	0.00	153.14
RADIOLOGY THERAPEUTIC	621,305.87	69,772.48
OCCUPATIONAL THERAPY	768,519.31	10,035.65
SPEECH PATHOLOGY	900,784.96	9,327.65
RENAL DIALYSIS	0.00	4,936.13
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	393,234.96	28,154.19
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	14,511.51	0.00
OTHER IMAGING SERVICES	891,061.08	20,020.31
BLOOD	327.05	478.75
BLOOD STORAGE & PRO.	360,692.45	115,474.91
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	309,861.44	3,913.56
AUDIOLOGY	0.00	0.00
CARDIOLOGY	254,699.28	89,889.53
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	69,365.59	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,290,530.12	39,686.78
OTHER LAB SERVICES	353,876.75	1,578.84
RECREATIONAL THERAPY	81.88	0.00
EDUCATION & TRAINING	20,249.38	2,228.80
OTHER THERAPEUTIC SERVI	768.12	10,486.00
SPECIAL CHARGES	85,899.22	0.00
FEE SCHEDULE LAB	5,494,786.19	607,444.30
MRI SERVICES	1,471,364.29	62,894.73

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	225.17	110.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	42,998.98
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	3,853.65
INJECTABLE DRUGS	226,148.36	470,445.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	129.95
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	101,414.60

TOTAL ANCILLARY	36,089,919.68	3,198,188.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,089,919.68	3,198,188.32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	137,121.85	ADJUSTMENTS	0.00
COVERED CHARGES	124,014.72	CONTRACTUAL ALLOW	87,574.30
NON-COVERED CHARGES	13,107.13	TOTAL MEDICAID LIAB	36,440.42
		LESS: COB	36,182.42
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	0.00
		ALL OTHER	4,357.19-
		FEE SCHEDULE-LAB	4,170.61
		INJECTABLE DRUGS	186.58

TOTAL NUMBER OF CLAIMS 109

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,250.65	0.00
MED/SURG SUPPLY	5,375.76	134.74
LABORATORY-GENERAL	0.00	1,135.82
RADIOLOGY-DIAGNOSTIC	5,014.70	780.83
CT SCAN	21,804.73	1,412.20
PHYSICAL THERAPY	8,182.78	501.48
EKG/ECG	519.32	0.00
IV THERAPY	422.64	411.32
OPERATING ROOM	3,909.56	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,342.84	0.00
RECOVERY ROOM	1,087.79	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,542.12	0.00
OCCUPATIONAL THERAPY	6,451.45	0.00
SPEECH PATHOLOGY	2,372.81	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	708.36	664.04
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,861.17	3,439.16
BLOOD	2,041.70	0.00
BLOOD STORAGE & PRO.	453.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,661.58	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,438.41	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,793.08	0.00
OTHER LAB SERVICES	609.27	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	226.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,872.45	1,989.99
MRI SERVICES	6,614.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	604.75	1,182.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,228.50

TOTAL ANCILLARY	124,014.72	13,107.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	124,014.72	13,107.13

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,389,468.91	ADJUSTMENTS	2,642.70
COVERED CHARGES	1,361,829.70	CONTRACTUAL ALLOW	1,213,617.65
NON-COVERED CHARGES	27,639.21	TOTAL MEDICAID LIAB	148,212.05
		LESS: COB	20.52
		LESS: COPAYMENT	2,400.00
		REIMBURSEMENT	145,791.53

TOTAL NUMBER OF CLAIMS 2,940

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,265.85	0.00
MED/SURG SUPPLY	48,601.89	1,606.38
LABORATORY-GENERAL	201,644.77	10,312.96
RADIOLOGY-DIAGNOSTIC	80,816.83	196.52
CT SCAN	75,658.06	9,660.70
PHYSICAL THERAPY	1,267.05	630.00
EKG/ECG	7,010.82	0.00
IV THERAPY	4,637.49	843.18
OPERATING ROOM	15,397.34	0.00
LABOR/DELIVERY ROOM	625.00	0.00
RESPIRATORY SERVICES	2,133.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	807,901.53	230.22
RECOVERY ROOM	2,403.87	0.00
LABORATORY PATHOLOGIC	1,064.63	0.00
RADIOLOGY THERAPEUTIC	6,552.97	0.00
OCCUPATIONAL THERAPY	2,074.77	0.00
SPEECH PATHOLOGY	1,417.74	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	95.45	124.76
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,488.18	370.86
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,991.18	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,122.34	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	849.22	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,897.96	1,066.68
OTHER LAB SERVICES	8,751.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,282.00	0.00
MRI SERVICES	10,279.95	1,960.65

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,598.55	497.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	139.25

TOTAL ANCILLARY	1,361,829.70	27,639.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,361,829.70	27,639.21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,894.90	ADJUSTMENTS	0.00
COVERED CHARGES	9,769.74	CONTRACTUAL ALLOW	8,223.15
NON-COVERED CHARGES	1,125.16	TOTAL MEDICAID LIAB	1,546.59
		LESS: COB	1,537.59
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345.05	133.40
MED/SURG SUPPLY	155.19	0.00
LABORATORY-GENERAL	1,655.89	309.16
RADIOLOGY-DIAGNOSTIC	379.73	0.00
CT SCAN	1,463.16	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	129.83	0.00
IV THERAPY	1,347.35	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,255.44	402.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38.10	280.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,769.74	1,125.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,769.74	1,125.16

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,126,418.79	ADJUSTMENTS	44,580.52
COVERED CHARGES	5,717,968.26	CONTRACTUAL ALLOW	4,482,464.81
NON-COVERED CHARGES	408,450.53	TOTAL MEDICAID LIAB	1,235,503.45
		LESS: COB	0.00
		LESS: COPAYMENT	1,743.00
		REIMBURSEMENT	1,233,760.45

TOTAL NUMBER OF CLAIMS 247

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0085GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	193,941.39	427.80
MED/SURG SUPPLY	2,424,057.99	32,809.21
LABORATORY-GENERAL	0.00	943.46
RADIOLOGY-DIAGNOSTIC	183,346.09	46,958.82
CT SCAN	16,520.05	1,463.16
PHYSICAL THERAPY	4,037.09	0.00
EKG/ECG	6,861.75	0.00
IV THERAPY	24,495.29	8,791.61
OPERATING ROOM	1,425,541.53	86,025.55
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,416.98	47.39
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,347.30	0.00
RECOVERY ROOM	200,425.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	234,590.95	30,322.48
OCCUPATIONAL THERAPY	270.33	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	4,884.88
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,863.42	483.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,492.57	185.43
BLOOD	0.00	327.05
BLOOD STORAGE & PRO.	26,904.48	9,743.99
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,590.49	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,738.72	123,550.59
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,380.13	0.00
OTHER LAB SERVICES	1,015.44	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	181.80	0.00
OTHER THERAPEUTIC SERVI	0.00	4,075.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	875,272.87	6,139.93
MRI SERVICES	11,143.49	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	336.50	3,749.50
INJECTABLE DRUGS	18,195.86	46,391.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	5.65
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,123.88

TOTAL ANCILLARY	5,717,968.26	408,450.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,717,968.26	408,450.53

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,314.02	ADJUSTMENTS	0.00
COVERED CHARGES	19,614.52	CONTRACTUAL ALLOW	14,593.24
NON-COVERED CHARGES	699.50	TOTAL MEDICAID LIAB	5,021.28
		LESS: COB	4,988.28
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL MEDICAL CENTER
4700 WATERS AVE
SAVANNAH GA 31404-6220

PROVIDER NUMBER 000001273A
NUMBER OF BEDS 536
TITLE XVIII NO: HPH0085GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	726.75	0.00
MED/SURG SUPPLY	2,431.38	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,642.33	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,006.52	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	387.92	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	226.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,140.92	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42.80	473.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,614.52	699.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,614.52	699.50

INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,297,524.10	ADJUSTMENTS	77,996.48
COVERED CHARGES	1,218,191.14	CONTRACTUAL ALLOW	604,042.91
NON-COVERED CHARGES	79,332.96	TOTAL MEDICAID LIAB	614,148.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	614,148.23

TOTAL NUMBER OF ADMISSIONS 196

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	265	156	90,100.00	62,400.00
NURSERY CARE CHARGES	112	20	30,800.00	5,500.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	377	176	120,900.00	67,900.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	377	176	120,900.00	67,900.00

INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	324,814.34	0.00
MED/SURG SUPPLY	166,710.25	34.00
LABORATORY-GENERAL	111,752.00	0.00
RADIOLOGY-DIAGNOSTIC	20,597.00	0.00
CT SCAN	59,230.00	132.00
PHYSICAL THERAPY	3,248.00	0.00
EKG/ECG	3,289.00	0.00
IV THERAPY	24,450.00	0.00
OPERATING ROOM	121,912.00	0.00
LABOR/DELIVERY ROOM	68,136.00	0.00
RESPIRATORY SERVICES	73,081.00	0.00
ANESTHESIA	18,577.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,284.00	0.00
RECOVERY ROOM	7,965.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,420.00	0.00
SPEECH PATHOLOGY	3,569.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,976.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,361.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,554.00	6,032.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,231.55	0.00
AUDIOLOGY	1,716.00	0.00
CARDIOLOGY	10,311.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,025.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	33,053.00	0.00
OTHER LAB SERVICES	4,005.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,258.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,097,291.14	11,432.96
TOTAL ACCOMODATIONS	120,900.00	67,900.00
TOTAL CHARGES	1,218,191.14	79,332.96

ZERO PAID INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	79,971.73	ADJUSTMENTS	0.00
COVERED CHARGES	72,307.73	CONTRACTUAL ALLOW	2,848.08-
NON-COVERED CHARGES	7,664.00	TOTAL MEDICAID LIAB	75,155.81
		LESS: COB	75,155.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6	19	2,040.00	7,200.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	19	2,040.00	7,200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	19	2,040.00	7,200.00

ZERO PAID INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,392.43	0.00
MED/SURG SUPPLY	9,292.30	0.00
LABORATORY-GENERAL	6,708.00	0.00
RADIOLOGY-DIAGNOSTIC	1,056.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	750.00	0.00
OPERATING ROOM	21,900.00	0.00
LABOR/DELIVERY ROOM	4,098.00	0.00
RESPIRATORY SERVICES	3,113.00	0.00
ANESTHESIA	1,135.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	45.00	0.00
RECOVERY ROOM	992.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	748.00	464.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	880.00	0.00
OTHER LAB SERVICES	158.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,267.73	464.00
TOTAL ACCOMODATIONS	2,040.00	7,200.00
TOTAL CHARGES	72,307.73	7,664.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,496,862.11	ADJUSTMENTS	301,152.88
COVERED CHARGES	2,421,048.05	CONTRACTUAL ALLOW	642,883.90
NON-COVERED CHARGES	75,814.06	TOTAL MEDICAID LIAB	1,778,164.15
		LESS: COB	6,270.95
		LESS: COPAYMENT	2,757.00
		REIMBURSEMENT	1,769,136.20
		ALL OTHER	1,717,924.82
		FEE SCHEDULE-LAB	51,211.38
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,811

OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	465,105.83	2,877.19
MED/SURG SUPPLY	191,562.61	1,230.00
LABORATORY-GENERAL	840.00	1,322.00
RADIOLOGY-DIAGNOSTIC	134,325.00	1,896.00
CT SCAN	152,587.00	3,007.00
PHYSICAL THERAPY	109,465.00	1,768.00
EKG/ECG	13,715.00	0.00
IV THERAPY	36,525.00	750.00
OPERATING ROOM	75,179.00	9,534.00
LABOR/DELIVERY ROOM	3,418.00	0.00
RESPIRATORY SERVICES	30,211.00	316.00
ANESTHESIA	14,696.00	0.00
GI SERVICES	7,745.00	0.00
EMERGENCY ROOM	247,815.00	688.00
RECOVERY ROOM	10,781.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	80,941.00	574.00
SPEECH PATHOLOGY	211,562.00	285.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	30,933.79	50.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,328.00	2,426.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,212.00	5,312.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,428.16	1,320.57
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,257.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,125.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	107,904.00	180.00
OTHER LAB SERVICES	39,027.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	283,271.66	38,374.30
MRI SERVICES	50,600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	529.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	1,488.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,333.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42.00

TOTAL ANCILLARY	2,421,048.05	75,814.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,421,048.05	75,814.06

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	30,783.73	ADJUSTMENTS	0.00
COVERED CHARGES	30,090.73	CONTRACTUAL ALLOW	5,534.81
NON-COVERED CHARGES	693.00	TOTAL MEDICAID LIAB	24,555.92
		LESS: COB	24,423.92
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	0.00
		ALL OTHER	987.67-
		FEE SCHEDULE-LAB	987.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 95

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,954.43	0.00
MED/SURG SUPPLY	1,298.30	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,605.00	0.00
CT SCAN	3,057.00	0.00
PHYSICAL THERAPY	1,152.00	128.00
EKG/ECG	352.00	0.00
IV THERAPY	750.00	0.00
OPERATING ROOM	222.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	283.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,514.00	92.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	256.00	128.00
SPEECH PATHOLOGY	4,653.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	165.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,766.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,973.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,090.00	345.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,090.73	693.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,090.73	693.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	100,466.69	ADJUSTMENTS	3,210.00
COVERED CHARGES	99,301.69	CONTRACTUAL ALLOW	82,721.69
NON-COVERED CHARGES	1,165.00	TOTAL MEDICAID LIAB	16,580.00
		LESS: COB	0.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	16,367.00

TOTAL NUMBER OF CLAIMS 332

OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
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COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,694.49	0.00
MED/SURG SUPPLY	3,792.20	148.00
LABORATORY-GENERAL	8,491.00	1,017.00
RADIOLOGY-DIAGNOSTIC	4,587.00	0.00
CT SCAN	3,390.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	242.00	0.00
IV THERAPY	825.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	184.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	60,775.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	41.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	745.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,930.00	0.00
OTHER LAB SERVICES	605.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	99,301.69	1,165.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,301.69	1,165.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	763.25	ADJUSTMENTS	0.00
COVERED CHARGES	523.25	CONTRACTUAL ALLOW	125.20
NON-COVERED CHARGES	240.00	TOTAL MEDICAID LIAB	398.05
		LESS: COB	398.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
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PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87.25	0.00
MED/SURG SUPPLY	12.00	0.00
LABORATORY-GENERAL	115.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	309.00	240.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	523.25	240.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	523.25	240.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	350,839.07	ADJUSTMENTS	20,669.50
COVERED CHARGES	340,106.50	CONTRACTUAL ALLOW	178,837.60
NON-COVERED CHARGES	10,732.57	TOTAL MEDICAID LIAB	161,268.90
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	161,217.90

TOTAL NUMBER OF CLAIMS 39

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
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NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,966.77	0.00
MED/SURG SUPPLY	65,107.75	0.00
LABORATORY-GENERAL	420.00	168.00
RADIOLOGY-DIAGNOSTIC	4,311.00	0.00
CT SCAN	26,883.00	1,389.00
PHYSICAL THERAPY	1,470.00	0.00
EKG/ECG	1,199.00	0.00
IV THERAPY	4,050.00	0.00
OPERATING ROOM	47,603.00	881.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,493.00	55.00
ANESTHESIA	5,647.00	650.00
GI SERVICES	1,320.00	0.00
EMERGENCY ROOM	3,603.00	0.00
RECOVERY ROOM	3,088.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	768.00	0.00
SPEECH PATHOLOGY	0.00	331.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,079.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,372.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,211.00	928.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,050.98	180.57
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,444.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,565.00	480.00
OTHER LAB SERVICES	1,782.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,563.00	5,670.00
MRI SERVICES	11,110.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	340,106.50	10,732.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	340,106.50	10,732.57

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,833,235.36	ADJUSTMENTS	95,249.39
COVERED CHARGES	1,761,559.36	CONTRACTUAL ALLOW	922,925.72
NON-COVERED CHARGES	71,676.00	TOTAL MEDICAID LIAB	838,633.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	838,633.64

TOTAL NUMBER OF ADMISSIONS 272

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	423	103	145,778.00	42,102.00
NURSERY CARE CHARGES	128	0	35,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	551	103	180,978.00	42,102.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	551	103	180,978.00	42,102.00

INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	463,265.66	0.00
MED/SURG SUPPLY	213,866.40	0.00
LABORATORY-GENERAL	144,650.00	0.00
RADIOLOGY-DIAGNOSTIC	61,364.00	0.00
CT SCAN	75,510.00	0.00
PHYSICAL THERAPY	1,904.00	0.00
EKG/ECG	4,521.00	0.00
IV THERAPY	5,175.00	0.00
OPERATING ROOM	259,045.30	0.00
LABOR/DELIVERY ROOM	113,563.00	0.00
RESPIRATORY SERVICES	90,159.00	0.00
ANESTHESIA	22,725.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,996.00	0.00
RECOVERY ROOM	9,083.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	488.00	0.00
SPEECH PATHOLOGY	44.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	570.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,111.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,984.00	5,104.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,750.00	0.00
AUDIOLOGY	2,464.00	0.00
CARDIOLOGY	8,838.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,000.00	0.00
OTHER LAB SERVICES	2,795.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,280.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	23,900.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,580,581.36	29,574.00
TOTAL ACCOMODATIONS	180,978.00	42,102.00
TOTAL CHARGES	1,761,559.36	71,676.00

ZERO PAID INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,905.94	ADJUSTMENTS	0.00
COVERED CHARGES	10,105.94	CONTRACTUAL ALLOW	282.98-
NON-COVERED CHARGES	1,800.00	TOTAL MEDICAID LIAB	10,388.92
		LESS: COB	10,388.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	2	340.00	800.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	2	340.00	800.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	2	340.00	800.00

ZERO PAID INPATIENT PAID CLAIMS

MILLER CO HOSP
209 N CUTHBERT ST
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COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,145.94	0.00
MED/SURG SUPPLY	1,429.00	0.00
LABORATORY-GENERAL	754.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,812.00	0.00
RESPIRATORY SERVICES	1,590.00	0.00
ANESTHESIA	495.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	240.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,000.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,765.94	1,000.00
TOTAL ACCOMODATIONS	340.00	800.00
TOTAL CHARGES	10,105.94	1,800.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,759,459.11	ADJUSTMENTS	148,502.86
COVERED CHARGES	2,648,389.03	CONTRACTUAL ALLOW	1,390,254.70
NON-COVERED CHARGES	111,070.08	TOTAL MEDICAID LIAB	1,258,134.33
		LESS: COB	2,380.57
		LESS: COPAYMENT	4,839.00
		REIMBURSEMENT	1,250,914.76
		ALL OTHER	1,172,842.51
		FEE SCHEDULE-LAB	78,072.25
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,838

OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	347,358.51	1,669.15
MED/SURG SUPPLY	194,396.70	953.00
LABORATORY-GENERAL	0.00	852.00
RADIOLOGY-DIAGNOSTIC	163,854.00	1,219.00
CT SCAN	188,929.00	12,996.00
PHYSICAL THERAPY	112,925.00	3,591.00
EKG/ECG	15,246.00	99.00
IV THERAPY	17,625.00	1,200.00
OPERATING ROOM	80,985.00	7,014.00
LABOR/DELIVERY ROOM	14,844.00	0.00
RESPIRATORY SERVICES	42,812.00	65.00
ANESTHESIA	17,368.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	273,264.00	560.00
RECOVERY ROOM	10,612.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	59,725.50	0.00
SPEECH PATHOLOGY	204,067.50	285.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	40,200.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	133,511.00	4,892.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	940.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,415.14	2,422.33
AUDIOLOGY	132.00	0.00
CARDIOLOGY	33,149.28	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,175.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	142,505.00	220.00
OTHER LAB SERVICES	36,712.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	434,851.40	68,142.60
MRI SERVICES	60,940.00	1,650.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,900.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	786.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,648,389.03	110,670.08
TOTAL ACCOMODATIONS	0.00	400.00
TOTAL CHARGES	2,648,389.03	111,070.08

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
209 N CUTHBERT ST
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PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,348.60	ADJUSTMENTS	0.00
COVERED CHARGES	22,021.76	CONTRACTUAL ALLOW	5,886.45
NON-COVERED CHARGES	1,326.84	TOTAL MEDICAID LIAB	16,135.31
		LESS: COB	15,784.31
		LESS: COPAYMENT	351.00
		REIMBURSEMENT	0.00
		ALL OTHER	944.38-
		FEE SCHEDULE-LAB	944.38
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 152

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER CO HOSP
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PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	790.76	170.84
MED/SURG SUPPLY	854.00	0.00
LABORATORY-GENERAL	0.00	186.00
RADIOLOGY-DIAGNOSTIC	360.00	0.00
CT SCAN	1,783.00	0.00
PHYSICAL THERAPY	1,313.00	150.00
EKG/ECG	220.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	602.00	0.00
RESPIRATORY SERVICES	253.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,931.00	293.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	210.00	0.00
SPEECH PATHOLOGY	846.00	141.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	80.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,102.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,473.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	360.00	0.00
OTHER LAB SERVICES	158.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,946.00	386.00
MRI SERVICES	3,740.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22,021.76	1,326.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,021.76	1,326.84

OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
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COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	155,322.26	ADJUSTMENTS	920.00
COVERED CHARGES	152,630.96	CONTRACTUAL ALLOW	127,345.96
NON-COVERED CHARGES	2,691.30	TOTAL MEDICAID LIAB	25,285.00
		LESS: COB	0.00
		LESS: COPAYMENT	555.00
		REIMBURSEMENT	24,730.00

TOTAL NUMBER OF CLAIMS 506

OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
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PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,697.31	0.00
MED/SURG SUPPLY	7,345.95	208.00
LABORATORY-GENERAL	15,761.70	2,333.30
RADIOLOGY-DIAGNOSTIC	9,104.00	150.00
CT SCAN	1,927.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,081.00	0.00
IV THERAPY	750.00	0.00
OPERATING ROOM	263.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	621.00	0.00
ANESTHESIA	448.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,651.00	0.00
RECOVERY ROOM	193.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,677.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,955.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	156.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	152,630.96	2,691.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	152,630.96	2,691.30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,774.95	ADJUSTMENTS	0.00
COVERED CHARGES	1,490.95	CONTRACTUAL ALLOW	503.05
NON-COVERED CHARGES	284.00	TOTAL MEDICAID LIAB	987.90
		LESS: COB	987.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	228.95	0.00
MED/SURG SUPPLY	20.00	0.00
LABORATORY-GENERAL	332.00	12.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	910.00	272.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,490.95	284.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,490.95	284.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	328,891.72	ADJUSTMENTS	67,195.58
COVERED CHARGES	318,408.72	CONTRACTUAL ALLOW	180,401.45
NON-COVERED CHARGES	10,483.00	TOTAL MEDICAID LIAB	138,007.27
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	137,911.27

TOTAL NUMBER OF CLAIMS 39

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP119

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,461.03	0.00
MED/SURG SUPPLY	77,069.39	0.00
LABORATORY-GENERAL	0.00	952.00
RADIOLOGY-DIAGNOSTIC	6,353.00	0.00
CT SCAN	30,814.00	2,979.00
PHYSICAL THERAPY	213.00	0.00
EKG/ECG	1,111.00	0.00
IV THERAPY	2,775.00	0.00
OPERATING ROOM	33,237.30	2,261.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,953.00	117.00
ANESTHESIA	5,193.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,078.00	0.00
RECOVERY ROOM	3,088.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	70.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,163.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	464.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,440.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,390.00	3,210.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	500.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	318,408.72	10,483.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	318,408.72	10,483.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER CO HOSP
209 N CUTHBERT ST
PO BOX 7
COLQUITT GA 39837-3518

PROVIDER NUMBER 000001317A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP119

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	772,655.43	ADJUSTMENTS	12,519.74
COVERED CHARGES	766,094.77	CONTRACTUAL ALLOW	192,342.35
NON-COVERED CHARGES	6,560.66	TOTAL MEDICAID LIAB	573,752.42
		LESS: COB	2,154.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	571,598.38

TOTAL NUMBER OF ADMISSIONS 243

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	547	0	98,591.52	3,505.23
NURSERY CARE CHARGES	17	0	2,688.78	812.60
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	564	0	101,280.30	4,317.83
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	564	0	101,280.30	4,317.83

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298,092.10	0.00
MED/SURG SUPPLY	186,137.56	0.00
LABORATORY-GENERAL	53,698.70	1,992.83
RADIOLOGY-DIAGNOSTIC	5,456.62	0.00
CT SCAN	3,780.00	0.00
PHYSICAL THERAPY	1,403.40	0.00
EKG/ECG	1,551.64	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	24,333.75	0.00
LABOR/DELIVERY ROOM	38,856.75	0.00
RESPIRATORY SERVICES	3,752.71	0.00
ANESTHESIA	21,020.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,693.75	0.00
RECOVERY ROOM	5,391.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,125.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,350.00	250.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,120.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	125.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,902.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	664,814.47	2,242.83
TOTAL ACCOMODATIONS	101,280.30	4,317.83
TOTAL CHARGES	766,094.77	6,560.66

ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,072,479.45	ADJUSTMENTS	15,760.48
COVERED CHARGES	937,372.73	CONTRACTUAL ALLOW	391,237.12
NON-COVERED CHARGES	135,106.72	TOTAL MEDICAID LIAB	546,135.61
		LESS: COB	12.43
		LESS: COPAYMENT	1,626.00
		REIMBURSEMENT	544,497.18
		ALL OTHER	506,947.77
		FEE SCHEDULE-LAB	37,540.36
		INJECTABLE DRUGS	9.05

TOTAL NUMBER OF CLAIMS 2,449

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,822.45	23,044.39
MED/SURG SUPPLY	132,629.22	5,097.74
LABORATORY-GENERAL	0.00	23,248.01
RADIOLOGY-DIAGNOSTIC	65,452.45	11,017.39
CT SCAN	55,394.17	4,645.00
PHYSICAL THERAPY	31,424.46	3,723.59
EKG/ECG	10,213.76	711.58
IV THERAPY	4,736.26	0.00
OPERATING ROOM	8,422.25	2,782.50
LABOR/DELIVERY ROOM	4,557.75	0.00
RESPIRATORY SERVICES	6,549.91	362.76
ANESTHESIA	5,817.16	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	110,530.83	2,802.50
RECOVERY ROOM	3,412.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	240.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	29,254.00	3,925.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	450.00	225.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,200.00	0.00
AMBULATORY SURGERY	500.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,656.50	9,106.50
OTHER LAB SERVICES	2,150.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	158,867.83	42,430.61
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	91.23	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	128.27

TOTAL ANCILLARY	937,372.73	133,250.84
TOTAL ACCOMODATIONS	0.00	1,855.88
TOTAL CHARGES	937,372.73	135,106.72

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,190.44	ADJUSTMENTS	0.00
COVERED CHARGES	6,596.64	CONTRACTUAL ALLOW	39.43-
NON-COVERED CHARGES	593.80	TOTAL MEDICAID LIAB	6,636.07
		LESS: COB	6,630.07
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	77.61-
		FEE SCHEDULE-LAB	77.61
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,708.97	0.00
MED/SURG SUPPLY	2,799.32	0.00
LABORATORY-GENERAL	0.00	49.80
RADIOLOGY-DIAGNOSTIC	190.65	176.50
CT SCAN	500.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	64.62	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	367.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	262.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	78.75	0.00
RECOVERY ROOM	409.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	294.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	288.33	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,596.64	593.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,596.64	593.80

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	100,342.59	ADJUSTMENTS	829.00
COVERED CHARGES	94,546.21	CONTRACTUAL ALLOW	66,304.21
NON-COVERED CHARGES	5,796.38	TOTAL MEDICAID LIAB	28,242.00
		LESS: COB	0.00
		LESS: COPAYMENT	810.00
		REIMBURSEMENT	27,432.00

TOTAL NUMBER OF CLAIMS 604

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,904.96	184.28
MED/SURG SUPPLY	7,955.40	0.00
LABORATORY-GENERAL	14,487.86	4,090.61
RADIOLOGY-DIAGNOSTIC	5,375.66	1,521.49
CT SCAN	3,140.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	581.58	0.00
IV THERAPY	400.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	64.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	35,555.25	0.00
RECOVERY ROOM	273.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	808.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	94,546.21	5,796.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,546.21	5,796.38

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,394.48	ADJUSTMENTS	0.00
COVERED CHARGES	1,004.78	CONTRACTUAL ALLOW	1,004.78
NON-COVERED CHARGES	4,389.70	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.78	390.06
MED/SURG SUPPLY	0.00	428.25
LABORATORY-GENERAL	899.00	1,882.08
RADIOLOGY-DIAGNOSTIC	0.00	468.44
CT SCAN	0.00	500.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	64.62
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	656.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,004.78	4,389.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,004.78	4,389.70

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	173,480.52	ADJUSTMENTS	0.00
COVERED CHARGES	159,228.09	CONTRACTUAL ALLOW	95,914.27
NON-COVERED CHARGES	14,252.43	TOTAL MEDICAID LIAB	63,313.82
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	63,310.82

TOTAL NUMBER OF CLAIMS 16

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,815.75	0.00
MED/SURG SUPPLY	23,588.08	0.00
LABORATORY-GENERAL	0.00	2,291.50
RADIOLOGY-DIAGNOSTIC	940.90	149.01
CT SCAN	2,540.00	0.00
PHYSICAL THERAPY	0.00	1,717.80
EKG/ECG	193.86	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	735.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,056.58	0.00
ANESTHESIA	1,927.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	646.25	0.00
RECOVERY ROOM	409.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	175.00	275.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	675.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,400.00	0.00
AMBULATORY SURGERY	250.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,659.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,950.92	9,084.12
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	159,228.09	14,252.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,228.09	14,252.43

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,002,099.17	ADJUSTMENTS	58,618.61
COVERED CHARGES	1,871,710.88	CONTRACTUAL ALLOW	1,046,086.18
NON-COVERED CHARGES	130,388.29	TOTAL MEDICAID LIAB	825,624.70
		LESS: COB	9,335.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	816,289.54

TOTAL NUMBER OF ADMISSIONS 316

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	855	2	167,136.81	83,207.70
NURSERY CARE CHARGES	27	2	4,988.52	3,406.59
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	882	6	172,125.33	86,614.29
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	882	6	172,125.33	86,614.29

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	642,804.54	0.00
MED/SURG SUPPLY	495,079.00	0.00
LABORATORY-GENERAL	208,348.01	13,835.00
RADIOLOGY-DIAGNOSTIC	24,081.00	0.00
CT SCAN	13,080.00	0.00
PHYSICAL THERAPY	8,160.00	0.00
EKG/ECG	8,060.00	0.00
IV THERAPY	3,466.00	0.00
OPERATING ROOM	75,907.00	0.00
LABOR/DELIVERY ROOM	76,962.00	0.00
RESPIRATORY SERVICES	20,968.00	0.00
ANESTHESIA	50,838.00	1,233.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,759.00	0.00
RECOVERY ROOM	15,427.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,550.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,050.00	6,000.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	6,640.00	0.00
CARDIOLOGY	600.00	0.00
AMBULATORY SURGERY	750.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,494.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	22,515.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	562.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	191.00

TOTAL ANCILLARY	1,699,585.55	43,774.00
TOTAL ACCOMODATIONS	172,125.33	86,614.29
TOTAL CHARGES	1,871,710.88	130,388.29

ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,147.45	ADJUSTMENTS	0.00
COVERED CHARGES	12,731.00	CONTRACTUAL ALLOW	3,944.08
NON-COVERED CHARGES	1,416.45	TOTAL MEDICAID LIAB	8,786.92
		LESS: COB	8,786.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	612.00	21.45
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	612.00	21.45
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	612.00	21.45

ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,493.00	0.00
MED/SURG SUPPLY	4,154.00	0.00
LABORATORY-GENERAL	435.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,470.00	0.00
LABOR/DELIVERY ROOM	309.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,575.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	683.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,395.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,119.00	1,395.00
TOTAL ACCOMODATIONS	612.00	21.45
TOTAL CHARGES	12,731.00	1,416.45

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,235,364.26	ADJUSTMENTS	26,983.45
COVERED CHARGES	1,161,097.70	CONTRACTUAL ALLOW	500,766.99
NON-COVERED CHARGES	74,266.56	TOTAL MEDICAID LIAB	660,330.71
		LESS: COB	1,936.40
		LESS: COPAYMENT	1,128.00
		REIMBURSEMENT	657,266.31
		ALL OTHER	625,226.62
		FEE SCHEDULE-LAB	31,986.37
		INJECTABLE DRUGS	53.32

TOTAL NUMBER OF CLAIMS 2,002

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,554.02	1,491.00
MED/SURG SUPPLY	90,043.00	206.00
LABORATORY-GENERAL	1,484.00	15,996.00
RADIOLOGY-DIAGNOSTIC	103,508.99	5,563.00
CT SCAN	81,050.00	1,432.00
PHYSICAL THERAPY	55,149.00	304.00
EKG/ECG	10,400.00	130.00
IV THERAPY	11,400.00	0.00
OPERATING ROOM	3,616.00	1,485.00
LABOR/DELIVERY ROOM	10,672.00	465.00
RESPIRATORY SERVICES	4,225.00	457.00
ANESTHESIA	1,628.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	276,051.00	1,030.00
RECOVERY ROOM	819.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	56,111.00	50.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,250.00	4,800.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	80.00	0.00
CARDIOLOGY	6,000.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,000.50	1,008.00
OTHER LAB SERVICES	12,700.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	232,837.19	36,217.01
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	630.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	70.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	449.00	1,782.00

TOTAL ANCILLARY	1,161,097.70	73,046.01
TOTAL ACCOMODATIONS	0.00	1,220.55
TOTAL CHARGES	1,161,097.70	74,266.56

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	195,205.65	ADJUSTMENTS	741.00
COVERED CHARGES	190,407.65	CONTRACTUAL ALLOW	163,387.65
NON-COVERED CHARGES	4,798.00	TOTAL MEDICAID LIAB	27,020.00
		LESS: COB	0.00
		LESS: COPAYMENT	366.00
		REIMBURSEMENT	26,654.00

TOTAL NUMBER OF CLAIMS 541

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,612.65	0.00
MED/SURG SUPPLY	6,368.00	0.00
LABORATORY-GENERAL	28,365.00	3,435.00
RADIOLOGY-DIAGNOSTIC	10,353.00	1,188.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,040.00	0.00
IV THERAPY	1,600.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	927.00	0.00
RESPIRATORY SERVICES	256.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	96,739.00	175.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	147.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	190,407.65	4,798.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190,407.65	4,798.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	109,879.30	ADJUSTMENTS	3,960.22
COVERED CHARGES	103,150.00	CONTRACTUAL ALLOW	63,517.80
NON-COVERED CHARGES	6,729.30	TOTAL MEDICAID LIAB	39,632.20
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	39,617.20

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,598.00	0.00
MED/SURG SUPPLY	36,016.00	0.00
LABORATORY-GENERAL	0.00	544.00
RADIOLOGY-DIAGNOSTIC	701.00	100.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	390.00	130.00
IV THERAPY	200.00	0.00
OPERATING ROOM	5,643.50	2,940.00
LABOR/DELIVERY ROOM	927.00	0.00
RESPIRATORY SERVICES	1,201.00	112.00
ANESTHESIA	5,251.00	486.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,335.00	0.00
RECOVERY ROOM	1,638.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	750.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,021.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,478.00	1,062.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	933.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	103,150.00	6,307.00
TOTAL ACCOMODATIONS	0.00	422.30
TOTAL CHARGES	103,150.00	6,729.30

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 08/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	653,588.79	ADJUSTMENTS	21,849.33
COVERED CHARGES	580,161.79	CONTRACTUAL ALLOW	335,096.89
NON-COVERED CHARGES	73,427.00	TOTAL MEDICAID LIAB	245,064.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	245,064.90

TOTAL NUMBER OF ADMISSIONS 104

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	275	0	56,082.00	67,418.00
NURSERY CARE CHARGES	2	0	408.00	392.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	277	1	56,490.00	67,810.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	277	1	56,490.00	67,810.00

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188,652.25	0.00
MED/SURG SUPPLY	164,165.54	0.00
LABORATORY-GENERAL	55,677.00	4,117.00
RADIOLOGY-DIAGNOSTIC	5,216.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,080.00	0.00
IV THERAPY	1,800.00	0.00
OPERATING ROOM	22,261.00	0.00
LABOR/DELIVERY ROOM	37,935.00	0.00
RESPIRATORY SERVICES	7,193.00	0.00
ANESTHESIA	16,542.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,850.00	0.00
RECOVERY ROOM	5,463.00	0.00
LABORATORY PATHOLOGIC	388.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,700.00	1,500.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,880.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,869.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	523,671.79	5,617.00
TOTAL ACCOMODATIONS	56,490.00	67,810.00
TOTAL CHARGES	580,161.79	73,427.00

ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	330,598.58	ADJUSTMENTS	1,811.39
COVERED CHARGES	310,684.58	CONTRACTUAL ALLOW	112,363.40
NON-COVERED CHARGES	19,914.00	TOTAL MEDICAID LIAB	198,321.18
		LESS: COB	708.40
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	197,231.78
		ALL OTHER	187,119.44
		FEE SCHEDULE-LAB	10,112.34
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 620

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,098.60	0.00
MED/SURG SUPPLY	21,342.00	0.00
LABORATORY-GENERAL	0.00	2,349.00
RADIOLOGY-DIAGNOSTIC	23,396.00	2,990.00
CT SCAN	4,000.00	0.00
PHYSICAL THERAPY	18,582.00	0.00
EKG/ECG	2,340.00	0.00
IV THERAPY	4,400.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	5,045.00	0.00
RESPIRATORY SERVICES	1,714.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,970.00	175.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,270.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,829.00	1,302.00
OTHER LAB SERVICES	1,100.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	72,360.98	12,923.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	237.00	175.00

TOTAL ANCILLARY	310,684.58	19,914.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	310,684.58	19,914.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21.00	ADJUSTMENTS	0.00
COVERED CHARGES	21.00	CONTRACTUAL ALLOW	18.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.02
		FEE SCHEDULE-LAB	0.02-
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21.00	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	66,844.65	ADJUSTMENTS	250.00
COVERED CHARGES	64,332.65	CONTRACTUAL ALLOW	55,332.65
NON-COVERED CHARGES	2,512.00	TOTAL MEDICAID LIAB	9,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	8,850.00

TOTAL NUMBER OF CLAIMS 180

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,947.65	0.00
MED/SURG SUPPLY	2,698.00	0.00
LABORATORY-GENERAL	11,648.00	1,621.00
RADIOLOGY-DIAGNOSTIC	3,976.00	891.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	520.00	0.00
IV THERAPY	600.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	288.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,655.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,332.65	2,512.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,332.65	2,512.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	74,869.48	ADJUSTMENTS	0.00
COVERED CHARGES	71,702.48	CONTRACTUAL ALLOW	41,169.80
NON-COVERED CHARGES	3,167.00	TOTAL MEDICAID LIAB	30,532.68
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	30,520.68

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,219.50	102.00
MED/SURG SUPPLY	12,074.48	0.00
LABORATORY-GENERAL	0.00	668.00
RADIOLOGY-DIAGNOSTIC	961.00	297.00
CT SCAN	4,100.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	780.00	0.00
IV THERAPY	400.00	0.00
OPERATING ROOM	2,970.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,005.00	0.00
ANESTHESIA	945.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,165.00	0.00
RECOVERY ROOM	546.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	350.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,100.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,086.00	2,100.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	71,702.48	3,167.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	71,702.48	3,167.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,240,276.38	ADJUSTMENTS	30,905.57
COVERED CHARGES	1,139,496.38	CONTRACTUAL ALLOW	618,207.66
NON-COVERED CHARGES	100,780.00	TOTAL MEDICAID LIAB	521,288.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	521,288.72

TOTAL NUMBER OF ADMISSIONS 230

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	494	0	139,552.00	84,548.00
NURSERY CARE CHARGES	78	0	23,556.00	7,644.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	572	0	163,108.00	92,192.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	572	0	163,108.00	92,192.00

INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	239,756.00	0.00
MED/SURG SUPPLY	373,919.38	0.00
LABORATORY-GENERAL	100,906.00	7,996.00
RADIOLOGY-DIAGNOSTIC	10,678.00	0.00
CT SCAN	7,680.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,120.00	0.00
IV THERAPY	11,400.00	0.00
OPERATING ROOM	46,955.00	0.00
LABOR/DELIVERY ROOM	76,853.00	0.00
RESPIRATORY SERVICES	8,555.00	0.00
ANESTHESIA	40,917.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,970.00	0.00
RECOVERY ROOM	11,195.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	700.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,350.00	500.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	6,080.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,701.00	0.00
OTHER LAB SERVICES	1,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	92.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	253.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	976,388.38	8,588.00
TOTAL ACCOMODATIONS	163,108.00	92,192.00
TOTAL CHARGES	1,139,496.38	100,780.00

ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	902,021.70	ADJUSTMENTS	28,500.44
COVERED CHARGES	850,026.70	CONTRACTUAL ALLOW	329,892.50
NON-COVERED CHARGES	51,995.00	TOTAL MEDICAID LIAB	520,134.20
		LESS: COB	554.17
		LESS: COPAYMENT	1,041.00
		REIMBURSEMENT	518,539.03
		ALL OTHER	491,959.25
		FEE SCHEDULE-LAB	26,543.93
		INJECTABLE DRUGS	35.85

TOTAL NUMBER OF CLAIMS 1,405

OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,977.25	100.00
MED/SURG SUPPLY	91,388.44	0.00
LABORATORY-GENERAL	0.00	6,750.00
RADIOLOGY-DIAGNOSTIC	55,748.00	4,495.00
CT SCAN	31,580.00	0.00
PHYSICAL THERAPY	55,658.00	449.00
EKG/ECG	7,966.00	0.00
IV THERAPY	23,600.00	0.00
OPERATING ROOM	2,659.00	2,970.00
LABOR/DELIVERY ROOM	22,505.00	0.00
RESPIRATORY SERVICES	4,373.00	478.00
ANESTHESIA	2,100.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	212,484.00	285.00
RECOVERY ROOM	1,365.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	20,144.00	2,654.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	310.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,500.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,563.00	0.00
OTHER LAB SERVICES	4,000.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	193,057.01	33,607.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	49.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	850,026.70	51,788.00
TOTAL ACCOMODATIONS	0.00	207.00
TOTAL CHARGES	850,026.70	51,995.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	466.00	ADJUSTMENTS	0.00
COVERED CHARGES	466.00	CONTRACTUAL ALLOW	15.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	451.00
		LESS: COB	451.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	11.95-
		FEE SCHEDULE-LAB	11.95
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71.00	0.00
MED/SURG SUPPLY	29.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	146.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	466.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	466.00	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	220,618.55	ADJUSTMENTS	491.00
COVERED CHARGES	211,640.55	CONTRACTUAL ALLOW	181,400.55
NON-COVERED CHARGES	8,978.00	TOTAL MEDICAID LIAB	30,240.00
		LESS: COB	36.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	29,685.00

TOTAL NUMBER OF CLAIMS 605

OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,201.55	0.00
MED/SURG SUPPLY	9,785.00	0.00
LABORATORY-GENERAL	40,903.00	7,320.00
RADIOLOGY-DIAGNOSTIC	11,095.00	1,188.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,690.00	0.00
IV THERAPY	2,200.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	3,381.00	0.00
RESPIRATORY SERVICES	795.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	111,895.00	220.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	250.00	250.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	45.00	0.00
OTHER LAB SERVICES	1,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	211,640.55	8,978.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,640.55	8,978.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,634.00	ADJUSTMENTS	0.00
COVERED CHARGES	634.00	CONTRACTUAL ALLOW	356.30
NON-COVERED CHARGES	1,000.00	TOTAL MEDICAID LIAB	277.70
		LESS: COB	274.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	254.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	1,000.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	350.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	634.00	1,000.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	634.00	1,000.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD

GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	193,519.82	ADJUSTMENTS	13,567.08
COVERED CHARGES	180,890.82	CONTRACTUAL ALLOW	102,862.86
NON-COVERED CHARGES	12,629.00	TOTAL MEDICAID LIAB	78,027.96
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	78,003.96

TOTAL NUMBER OF CLAIMS 23

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0010GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,105.00	400.00
MED/SURG SUPPLY	76,758.25	0.00
LABORATORY-GENERAL	0.00	792.00
RADIOLOGY-DIAGNOSTIC	1,657.00	297.00
CT SCAN	7,160.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,430.00	0.00
IV THERAPY	1,400.00	0.00
OPERATING ROOM	14,711.00	7,043.00
LABOR/DELIVERY ROOM	618.00	0.00
RESPIRATORY SERVICES	643.00	0.00
ANESTHESIA	11,659.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,895.00	0.00
RECOVERY ROOM	3,959.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,800.00	500.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,990.57	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,070.00	2,597.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	180,890.82	11,629.00
TOTAL ACCOMODATIONS	0.00	1,000.00
TOTAL CHARGES	180,890.82	12,629.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPHS AT EAST GEORGIA INC
1201 SILOAM RD
GREENSBORO GA 30642-2811

PROVIDER NUMBER 000001328A
NUMBER OF BEDS 25
TITLE XVIII NO: HPH0010GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,680,340.59	ADJUSTMENTS	1,701.53
COVERED CHARGES	1,646,777.59	CONTRACTUAL ALLOW	799,299.48
NON-COVERED CHARGES	33,563.00	TOTAL MEDICAID LIAB	847,478.11
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	847,478.11

TOTAL NUMBER OF ADMISSIONS 403

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	634	0	251,035.00	15,665.00
NURSERY CARE CHARGES	291	0	98,940.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	925	0	349,975.00	15,665.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	925	0	349,975.00	15,665.00

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	408,768.23	210.00
MED/SURG SUPPLY	110,438.00	0.00
LABORATORY-GENERAL	185,972.00	36.00
RADIOLOGY-DIAGNOSTIC	20,896.00	0.00
CT SCAN	35,207.00	0.00
PHYSICAL THERAPY	674.00	0.00
EKG/ECG	1,767.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	156,875.92	0.00
LABOR/DELIVERY ROOM	191,116.00	0.00
RESPIRATORY SERVICES	53,645.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,641.00	0.00
EMERGENCY ROOM	41,316.00	0.00
RECOVERY ROOM	15,832.00	0.00
LABORATORY PATHOLOGIC	7,009.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,157.00	0.00
SPEECH PATHOLOGY	173.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,327.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,747.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,251.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	115.00
OTHER LAB SERVICES	26,482.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	17,537.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,508.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,296,802.59	17,898.00
TOTAL ACCOMODATIONS	349,975.00	15,665.00
TOTAL CHARGES	1,646,777.59	33,563.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	22,564.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,929.00	CONTRACTUAL ALLOW	4,151.39
NON-COVERED CHARGES	635.00	TOTAL MEDICAID LIAB	17,777.61
		LESS: COB	17,777.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	9	0	3,510.00	245.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9	0	3,510.00	245.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	9	0	3,510.00	245.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,209.00	0.00
MED/SURG SUPPLY	2,380.00	0.00
LABORATORY-GENERAL	1,793.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,625.00	0.00
LABOR/DELIVERY ROOM	1,082.00	0.00
RESPIRATORY SERVICES	550.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	562.00	0.00
LABORATORY PATHOLOGIC	190.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	567.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	390.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	309.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,419.00	390.00
TOTAL ACCOMODATIONS	3,510.00	245.00
TOTAL CHARGES	21,929.00	635.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,344,430.24	ADJUSTMENTS	14,422.76
COVERED CHARGES	2,233,372.56	CONTRACTUAL ALLOW	1,261,982.84
NON-COVERED CHARGES	111,057.68	TOTAL MEDICAID LIAB	971,389.72
		LESS: COB	271.56
		LESS: COPAYMENT	5,250.00
		REIMBURSEMENT	965,868.16
		ALL OTHER	897,351.22
		FEE SCHEDULE-LAB	66,651.53
		INJECTABLE DRUGS	1,865.41

TOTAL NUMBER OF CLAIMS 5,308

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,057.68	9,363.08
MED/SURG SUPPLY	59,520.00	138.00
LABORATORY-GENERAL	0.00	1,847.00
RADIOLOGY-DIAGNOSTIC	208,602.00	2,754.00
CT SCAN	231,821.00	4,247.00
PHYSICAL THERAPY	6,093.00	0.00
EKG/ECG	21,099.00	207.00
IV THERAPY	0.00	0.00
OPERATING ROOM	152,921.99	6,842.00
LABOR/DELIVERY ROOM	83,051.00	0.00
RESPIRATORY SERVICES	29,500.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	13,886.00	0.00
EMERGENCY ROOM	499,555.00	869.00
RECOVERY ROOM	25,946.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,247.00	110.00
SPEECH PATHOLOGY	502.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	75,933.00	5,057.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	672.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	22,755.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,992.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,070.00	4,025.00
OTHER LAB SERVICES	52,061.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	387,635.47	56,048.80
MRI SERVICES	92,968.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	18,229.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,484.42	1,299.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	21.00

TOTAL ANCILLARY	2,233,372.56	111,057.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,233,372.56	111,057.68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,619.20	ADJUSTMENTS	0.00
COVERED CHARGES	11,533.20	CONTRACTUAL ALLOW	2,755.79
NON-COVERED CHARGES	86.00	TOTAL MEDICAID LIAB	8,777.41
		LESS: COB	8,765.41
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	58.95-
		FEE SCHEDULE-LAB	51.59
		INJECTABLE DRUGS	7.36

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.20	70.00
MED/SURG SUPPLY	60.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	645.00	0.00
CT SCAN	3,102.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,710.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	909.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,083.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,512.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	345.00	5.00
MRI SERVICES	1,103.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	29.00	11.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,533.20	86.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,533.20	86.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	43,161.70	ADJUSTMENTS	150.00
COVERED CHARGES	41,696.70	CONTRACTUAL ALLOW	30,046.70
NON-COVERED CHARGES	1,465.00	TOTAL MEDICAID LIAB	11,650.00
		LESS: COB	14.96
		LESS: COPAYMENT	201.00
		REIMBURSEMENT	11,434.04

TOTAL NUMBER OF CLAIMS 233

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,258.00	184.00
MED/SURG SUPPLY	473.00	0.00
LABORATORY-GENERAL	6,266.00	1,146.00
RADIOLOGY-DIAGNOSTIC	1,423.00	0.00
CT SCAN	1,353.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	173.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,946.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	206.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,029.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	49.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	536.70	86.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	41,696.70	1,465.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,696.70	1,465.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	262.00	ADJUSTMENTS	0.00
COVERED CHARGES	262.00	CONTRACTUAL ALLOW	116.20
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	145.80
		LESS: COB	145.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	110.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	262.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	262.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST

CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	35,505.69	ADJUSTMENTS	3,821.46
COVERED CHARGES	33,668.69	CONTRACTUAL ALLOW	22,204.31
NON-COVERED CHARGES	1,837.00	TOTAL MEDICAID LIAB	11,464.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,464.38

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,579.70	0.00
MED/SURG SUPPLY	2,631.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	306.00	0.00
CT SCAN	3,758.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	99.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,849.99	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,096.00	0.00
RECOVERY ROOM	562.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,364.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,297.00	1,237.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	600.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	126.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,668.69	1,837.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,668.69	1,837.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,076,669.08	ADJUSTMENTS	16,453.53
COVERED CHARGES	2,047,337.08	CONTRACTUAL ALLOW	1,132,363.42
NON-COVERED CHARGES	29,332.00	TOTAL MEDICAID LIAB	914,973.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	914,973.66

TOTAL NUMBER OF ADMISSIONS 415

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	708	0	300,930.00	23,795.00
NURSERY CARE CHARGES	277	5	102,880.00	1,875.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	985	5	403,810.00	25,670.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	985	5	403,810.00	25,670.00

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	536,654.96	0.00
MED/SURG SUPPLY	115,521.00	0.00
LABORATORY-GENERAL	259,536.84	0.00
RADIOLOGY-DIAGNOSTIC	21,883.00	0.00
CT SCAN	54,980.00	0.00
PHYSICAL THERAPY	1,464.00	0.00
EKG/ECG	2,673.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	207,836.00	0.00
LABOR/DELIVERY ROOM	207,331.00	0.00
RESPIRATORY SERVICES	45,083.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,668.00	0.00
EMERGENCY ROOM	49,645.00	0.00
RECOVERY ROOM	20,952.00	0.00
LABORATORY PATHOLOGIC	7,338.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,085.00	0.00
SPEECH PATHOLOGY	665.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,666.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,948.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,864.00	0.00
CARDIOLOGY	3,060.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,575.00	3,662.00
OTHER LAB SERVICES	23,482.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47,615.48	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,643,527.08	3,662.00
TOTAL ACCOMODATIONS	403,810.00	25,670.00
TOTAL CHARGES	2,047,337.08	29,332.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	55,079.22	ADJUSTMENTS	0.00
COVERED CHARGES	54,419.22	CONTRACTUAL ALLOW	5,553.07
NON-COVERED CHARGES	660.00	TOTAL MEDICAID LIAB	48,866.15
		LESS: COB	48,866.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18	0	7,740.00	660.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18	0	7,740.00	660.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	18	0	7,740.00	660.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,056.22	0.00
MED/SURG SUPPLY	4,270.00	0.00
LABORATORY-GENERAL	4,479.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,698.00	0.00
LABOR/DELIVERY ROOM	9,986.00	0.00
RESPIRATORY SERVICES	216.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,260.00	0.00
LABORATORY PATHOLOGIC	403.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	150.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	663.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	832.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	666.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,679.22	0.00
TOTAL ACCOMODATIONS	7,740.00	660.00
TOTAL CHARGES	54,419.22	660.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,569,337.07	ADJUSTMENTS	182,056.84
COVERED CHARGES	3,423,266.82	CONTRACTUAL ALLOW	1,855,464.75
NON-COVERED CHARGES	146,070.25	TOTAL MEDICAID LIAB	1,567,802.07
		LESS: COB	589.16
		LESS: COPAYMENT	2,649.00
		REIMBURSEMENT	1,564,563.91
		ALL OTHER	1,463,571.91
		FEE SCHEDULE-LAB	88,458.38
		INJECTABLE DRUGS	12,533.62

TOTAL NUMBER OF CLAIMS 6,210

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	486,699.24	5,796.20
MED/SURG SUPPLY	112,617.00	194.00
LABORATORY-GENERAL	3,610.00	15,034.00
RADIOLOGY-DIAGNOSTIC	264,923.00	1,833.00
CT SCAN	288,887.00	879.00
PHYSICAL THERAPY	45,395.00	372.00
EKG/ECG	28,155.00	191.00
IV THERAPY	0.00	0.00
OPERATING ROOM	121,881.99	2,626.00
LABOR/DELIVERY ROOM	121,388.00	0.00
RESPIRATORY SERVICES	62,697.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	26,855.00	0.00
EMERGENCY ROOM	761,479.00	0.00
RECOVERY ROOM	21,260.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	21,151.00	222.00
SPEECH PATHOLOGY	7,034.00	362.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	122,684.00	3,587.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,825.00	1,287.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,328.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,257.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	148,876.00	20,125.00
OTHER LAB SERVICES	57,915.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	613,709.19	64,443.70
MRI SERVICES	56,559.00	1,116.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	213.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,081.40	27,789.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,423,266.82	146,070.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,423,266.82	146,070.25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	35,754.75	ADJUSTMENTS	0.00
COVERED CHARGES	34,571.75	CONTRACTUAL ALLOW	8,205.27
NON-COVERED CHARGES	1,183.00	TOTAL MEDICAID LIAB	26,366.48
		LESS: COB	26,360.48
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	984.25-
		FEE SCHEDULE-LAB	850.93
		INJECTABLE DRUGS	133.32

TOTAL NUMBER OF CLAIMS 62

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,873.75	26.00
MED/SURG SUPPLY	198.00	0.00
LABORATORY-GENERAL	0.00	237.00
RADIOLOGY-DIAGNOSTIC	1,435.00	0.00
CT SCAN	2,637.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	275.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	5,080.00	0.00
RESPIRATORY SERVICES	889.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,863.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,612.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	66.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,900.00	0.00
OTHER LAB SERVICES	1,664.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,919.00	821.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	226.00	33.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	34,571.75	1,183.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,571.75	1,183.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST

CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	69,038.80	ADJUSTMENTS	538.00
COVERED CHARGES	67,737.20	CONTRACTUAL ALLOW	53,487.20
NON-COVERED CHARGES	1,301.60	TOTAL MEDICAID LIAB	14,250.00
		LESS: COB	40.64
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	13,954.36

TOTAL NUMBER OF CLAIMS 285

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,456.50	0.00
MED/SURG SUPPLY	472.00	0.00
LABORATORY-GENERAL	12,381.00	614.00
RADIOLOGY-DIAGNOSTIC	3,121.00	0.00
CT SCAN	944.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	466.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	52.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	40,512.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	64.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	474.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	51.00	66.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,870.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	873.70	621.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,737.20	1,301.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,737.20	1,301.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,428.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,396.00	CONTRACTUAL ALLOW	450.14
NON-COVERED CHARGES	32.00	TOTAL MEDICAID LIAB	945.86
		LESS: COB	945.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	224.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,106.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	32.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,396.00	32.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,396.00	32.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST

CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	146,450.20	ADJUSTMENTS	11,458.38
COVERED CHARGES	144,420.20	CONTRACTUAL ALLOW	75,633.92
NON-COVERED CHARGES	2,030.00	TOTAL MEDICAID LIAB	68,786.28
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	68,753.28

TOTAL NUMBER OF CLAIMS 18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,096.20	0.00
MED/SURG SUPPLY	14,781.00	0.00
LABORATORY-GENERAL	190.00	190.00
RADIOLOGY-DIAGNOSTIC	931.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	10,631.00	0.00
EKG/ECG	420.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	28,429.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	201.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,189.00	0.00
EMERGENCY ROOM	3,217.00	0.00
RECOVERY ROOM	2,393.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,903.00	0.00
SPEECH PATHOLOGY	779.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	66.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,887.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,413.00	1,567.00
MRI SERVICES	5,733.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,227.00	207.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	144,420.20	2,030.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	144,420.20	2,030.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,020,419.05	ADJUSTMENTS	29,524.49
COVERED CHARGES	1,954,779.05	CONTRACTUAL ALLOW	1,239,246.33
NON-COVERED CHARGES	65,640.00	TOTAL MEDICAID LIAB	715,532.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	715,532.72

TOTAL NUMBER OF ADMISSIONS 323

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	544	0	251,950.00	10,270.00
NURSERY CARE CHARGES	245	0	94,345.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	789	0	346,295.00	10,270.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	789	0	346,295.00	10,270.00

INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	458,498.05	0.00
MED/SURG SUPPLY	120,256.00	0.00
LABORATORY-GENERAL	278,047.00	41.00
RADIOLOGY-DIAGNOSTIC	22,021.00	0.00
CT SCAN	45,923.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,134.00	0.00
IV THERAPY	43,552.00	0.00
OPERATING ROOM	162,544.00	0.00
LABOR/DELIVERY ROOM	240,109.00	0.00
RESPIRATORY SERVICES	40,928.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	645.00	0.00
EMERGENCY ROOM	51,325.00	0.00
RECOVERY ROOM	14,593.00	0.00
LABORATORY PATHOLOGIC	17,140.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	243.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,713.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,652.00	4,628.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,966.00	0.00
CARDIOLOGY	5,355.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,742.00	50,701.00
OTHER LAB SERVICES	21,118.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,196.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,784.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,608,484.05	55,370.00
TOTAL ACCOMODATIONS	346,295.00	10,270.00
TOTAL CHARGES	1,954,779.05	65,640.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	69,146.02	ADJUSTMENTS	0.00
COVERED CHARGES	68,078.02	CONTRACTUAL ALLOW	7,782.05
NON-COVERED CHARGES	1,068.00	TOTAL MEDICAID LIAB	60,295.97
		LESS: COB	60,295.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18	0	8,280.00	320.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18	0	8,280.00	320.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	18	0	8,280.00	320.00

ZERO PAID INPATIENT PAID CLAIMS

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,108.02	0.00
MED/SURG SUPPLY	4,525.00	0.00
LABORATORY-GENERAL	5,444.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	6,300.00	0.00
OPERATING ROOM	9,755.00	0.00
LABOR/DELIVERY ROOM	16,037.00	0.00
RESPIRATORY SERVICES	75.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	630.00	0.00
LABORATORY PATHOLOGIC	1,330.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,364.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	748.00
OTHER LAB SERVICES	1,040.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,190.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	59,798.02	748.00
TOTAL ACCOMODATIONS	8,280.00	320.00
TOTAL CHARGES	68,078.02	1,068.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,484,870.38	ADJUSTMENTS	363,357.82
COVERED CHARGES	4,280,466.53	CONTRACTUAL ALLOW	2,055,528.09
NON-COVERED CHARGES	204,403.85	TOTAL MEDICAID LIAB	2,224,938.44
		LESS: COB	486.66
		LESS: COPAYMENT	5,367.00
		REIMBURSEMENT	2,219,084.78
		ALL OTHER	2,073,062.23
		FEE SCHEDULE-LAB	98,445.59
		INJECTABLE DRUGS	47,576.96

TOTAL NUMBER OF CLAIMS 6,631

OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512,618.58	5,640.85
MED/SURG SUPPLY	85,637.00	307.00
LABORATORY-GENERAL	582.00	14,787.00
RADIOLOGY-DIAGNOSTIC	327,342.00	732.00
CT SCAN	397,388.00	48,983.00
PHYSICAL THERAPY	158,684.00	1,540.00
EKG/ECG	25,432.00	0.00
IV THERAPY	36,218.00	0.00
OPERATING ROOM	47,125.00	8,144.00
LABOR/DELIVERY ROOM	170,224.00	0.00
RESPIRATORY SERVICES	277,358.00	52.00
ANESTHESIA	0.00	0.00
GI SERVICES	12,497.00	0.00
EMERGENCY ROOM	843,419.00	797.00
RECOVERY ROOM	13,113.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	29,730.00	148.00
SPEECH PATHOLOGY	8,997.00	210.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	111,568.00	3,849.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,032.00	393.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,616.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	463.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	255,049.00	10,415.00
OTHER LAB SERVICES	56,651.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	726,254.00	83,023.00
MRI SERVICES	69,684.00	4,374.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	805.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79,784.95	20,204.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,280,466.53	204,403.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,280,466.53	204,403.85

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	42,460.56	ADJUSTMENTS	0.00
COVERED CHARGES	36,766.56	CONTRACTUAL ALLOW	3,086.05
NON-COVERED CHARGES	5,694.00	TOTAL MEDICAID LIAB	33,680.51
		LESS: COB	33,677.51
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,048.12-
		FEE SCHEDULE-LAB	984.21
		INJECTABLE DRUGS	63.91

TOTAL NUMBER OF CLAIMS 53

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,613.56	0.00
MED/SURG SUPPLY	738.00	0.00
LABORATORY-GENERAL	0.00	59.00
RADIOLOGY-DIAGNOSTIC	747.00	0.00
CT SCAN	923.00	2,717.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	192.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	8,250.00	0.00
RESPIRATORY SERVICES	52.00	52.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,250.00	264.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,626.00	158.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,076.00	362.00
OTHER LAB SERVICES	2,080.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,112.00	2,082.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	107.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	36,766.56	5,694.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,766.56	5,694.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	132,285.50	ADJUSTMENTS	891.00
COVERED CHARGES	129,663.50	CONTRACTUAL ALLOW	106,563.50
NON-COVERED CHARGES	2,622.00	TOTAL MEDICAID LIAB	23,100.00
		LESS: COB	40.20
		LESS: COPAYMENT	444.00
		REIMBURSEMENT	22,615.80

TOTAL NUMBER OF CLAIMS 462

OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,373.00	0.00
MED/SURG SUPPLY	540.00	0.00
LABORATORY-GENERAL	21,220.00	330.00
RADIOLOGY-DIAGNOSTIC	5,767.00	0.00
CT SCAN	1,425.00	1,846.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	300.00	0.00
IV THERAPY	300.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	4,000.00	0.00
RESPIRATORY SERVICES	124.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	73,383.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	486.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	53.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,891.00	0.00
OTHER LAB SERVICES	630.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,172.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,999.50	446.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	129,663.50	2,622.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	129,663.50	2,622.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	492.00	ADJUSTMENTS	0.00
COVERED CHARGES	492.00	CONTRACTUAL ALLOW	35.73
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	456.27
		LESS: COB	453.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	271.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	221.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	492.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	492.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST

CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	534,097.39	ADJUSTMENTS	42,489.21
COVERED CHARGES	528,002.39	CONTRACTUAL ALLOW	285,935.81
NON-COVERED CHARGES	6,095.00	TOTAL MEDICAID LIAB	242,066.58
		LESS: COB	0.00
		LESS: COPAYMENT	240.00
		REIMBURSEMENT	241,826.58

TOTAL NUMBER OF CLAIMS 74

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111331

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212,237.46	0.00
MED/SURG SUPPLY	29,624.00	0.00
LABORATORY-GENERAL	0.00	161.00
RADIOLOGY-DIAGNOSTIC	5,392.00	0.00
CT SCAN	13,237.00	0.00
PHYSICAL THERAPY	12,086.00	854.00
EKG/ECG	804.00	0.00
IV THERAPY	8,882.00	0.00
OPERATING ROOM	23,169.00	0.00
LABOR/DELIVERY ROOM	1,000.00	0.00
RESPIRATORY SERVICES	121,962.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,173.00	0.00
RECOVERY ROOM	3,232.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,543.00	116.00
SPEECH PATHOLOGY	95.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,635.00	778.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,530.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	295.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,467.00	0.00
OTHER LAB SERVICES	833.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,818.00	4,135.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,987.93	51.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	528,002.39	6,095.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	528,002.39	6,095.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL CO HOSPITAL
90 E STEPHENS ST
CAMILLA GA 31730-1836

PROVIDER NUMBER 000001339A
NUMBER OF BEDS 26
TITLE XVIII NO: 111331

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	269,337.11	ADJUSTMENTS	0.00
COVERED CHARGES	198,561.64	CONTRACTUAL ALLOW	12,332.51-
NON-COVERED CHARGES	70,775.47	TOTAL MEDICAID LIAB	210,894.15
		LESS: COB	3,896.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	206,997.55

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	0	126	0.00	44,100.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	0	126	0.00	44,100.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	2	0	1,370.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	1,370.00	0.00
TOTAL ACCOMODATIONS	2	126	1,370.00	44,100.00

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,740.38	0.00
MED/SURG SUPPLY	20,137.12	0.00
LABORATORY-GENERAL	40,334.69	172.22
RADIOLOGY-DIAGNOSTIC	9,001.09	0.00
CT SCAN	7,140.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,069.77	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	24,616.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,975.36	0.00
ANESTHESIA	0.00	17,403.75
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,466.20	0.00
RECOVERY ROOM	5,709.00	0.00
LABORATORY PATHOLOGIC	857.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	630.22	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25.47	8,483.42
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,263.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	200.00	0.00
OTHER LAB SERVICES	270.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,754.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	616.08

TOTAL ANCILLARY	197,191.64	26,675.47
TOTAL ACCOMODATIONS	1,370.00	44,100.00
TOTAL CHARGES	198,561.64	70,775.47

ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,049,659.12	ADJUSTMENTS	6,599.18
COVERED CHARGES	947,934.59	CONTRACTUAL ALLOW	437,733.81
NON-COVERED CHARGES	101,724.53	TOTAL MEDICAID LIAB	510,200.78
		LESS: COB	574.02
		LESS: COPAYMENT	1,905.00
		REIMBURSEMENT	507,721.76
		ALL OTHER	475,485.51
		FEE SCHEDULE-LAB	31,868.80
		INJECTABLE DRUGS	367.45

TOTAL NUMBER OF CLAIMS 2,644

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,512.00	3,925.27
MED/SURG SUPPLY	21,895.34	318.30
LABORATORY-GENERAL	199.76	11,500.99
RADIOLOGY-DIAGNOSTIC	142,244.92	5,240.78
CT SCAN	90,846.00	2,292.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,213.83	582.00
IV THERAPY	0.00	0.00
OPERATING ROOM	32,252.25	3,497.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,969.07	260.60
ANESTHESIA	0.00	29,238.38
GI SERVICES	0.00	0.00
EMERGENCY ROOM	318,156.80	3,616.30
RECOVERY ROOM	11,697.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	820.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,020.84	1,677.15
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,918.58
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	771.52	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,375.40	795.20
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,830.00	300.00
OTHER LAB SERVICES	2,519.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	149,797.33	34,163.70
MRI SERVICES	45,942.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,044.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,870.83	432.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	921.45

TOTAL ANCILLARY	947,934.59	101,724.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	947,934.59	101,724.53

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,173.47	ADJUSTMENTS	0.00
COVERED CHARGES	7,260.49	CONTRACTUAL ALLOW	814.05
NON-COVERED CHARGES	912.98	TOTAL MEDICAID LIAB	6,446.44
		LESS: COB	6,443.44
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	462.95-
		FEE SCHEDULE-LAB	462.95
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,076.26	48.40
MED/SURG SUPPLY	56.97	0.00
LABORATORY-GENERAL	49.94	184.58
RADIOLOGY-DIAGNOSTIC	1,244.19	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	104.24	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,315.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	496.86
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	370.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,965.89	30.24
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	140.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12.40	12.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,260.49	912.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,260.49	912.98

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	92,760.94	ADJUSTMENTS	100.00
COVERED CHARGES	88,576.86	CONTRACTUAL ALLOW	67,044.06
NON-COVERED CHARGES	4,184.08	TOTAL MEDICAID LIAB	21,532.80
		LESS: COB	36.00
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	21,208.80

TOTAL NUMBER OF CLAIMS 434

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,209.44	57.75
MED/SURG SUPPLY	1,447.18	15.49
LABORATORY-GENERAL	11,622.53	3,578.44
RADIOLOGY-DIAGNOSTIC	6,118.92	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	485.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	52.12	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	60,601.90	517.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	270.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	769.77	15.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	88,576.86	4,184.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,576.86	4,184.08

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	605.08	ADJUSTMENTS	0.00
COVERED CHARGES	605.08	CONTRACTUAL ALLOW	414.98
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	190.10
		LESS: COB	190.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.70	0.00
MED/SURG SUPPLY	47.26	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87.72	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	421.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	605.08	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	605.08	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	340,738.63	ADJUSTMENTS	0.00
COVERED CHARGES	267,629.77	CONTRACTUAL ALLOW	29,322.69
NON-COVERED CHARGES	73,108.86	TOTAL MEDICAID LIAB	238,307.08
		LESS: COB	530.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	237,776.46

TOTAL NUMBER OF ADMISSIONS 48

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	0	141	0.00	49,350.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	0	141	0.00	49,350.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	14	0	9,590.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	9,590.00	0.00
TOTAL ACCOMODATIONS	14	141	9,590.00	49,350.00

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,809.29	0.00
MED/SURG SUPPLY	23,734.98	0.00
LABORATORY-GENERAL	68,174.02	264.96
RADIOLOGY-DIAGNOSTIC	7,611.63	0.00
CT SCAN	14,402.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	20,996.47	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	12,299.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,423.88	0.00
ANESTHESIA	0.00	8,817.90
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,961.80	0.00
RECOVERY ROOM	3,510.00	0.00
LABORATORY PATHOLOGIC	1,066.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	12,723.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,953.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,049.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	258,039.77	23,758.86
TOTAL ACCOMODATIONS	9,590.00	49,350.00
TOTAL CHARGES	267,629.77	73,108.86

ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,229,166.79	ADJUSTMENTS	23,188.63
COVERED CHARGES	1,136,824.59	CONTRACTUAL ALLOW	536,173.87
NON-COVERED CHARGES	92,342.20	TOTAL MEDICAID LIAB	600,650.72
		LESS: COB	623.77
		LESS: COPAYMENT	1,407.00
		REIMBURSEMENT	598,619.95
		ALL OTHER	555,615.84
		FEE SCHEDULE-LAB	41,919.20
		INJECTABLE DRUGS	1,084.91

TOTAL NUMBER OF CLAIMS 2,734

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,269.15	5,073.66
MED/SURG SUPPLY	33,476.22	2.31
LABORATORY-GENERAL	306.00	10,397.57
RADIOLOGY-DIAGNOSTIC	130,312.85	1,099.27
CT SCAN	135,952.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	16,375.04	1,067.00
IV THERAPY	0.00	0.00
OPERATING ROOM	39,785.50	2,155.54
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,091.15	847.48
ANESTHESIA	0.00	29,083.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	397,613.90	57.40
RECOVERY ROOM	14,040.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,396.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,406.32	342.14
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,161.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	196.74	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,236.28	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,840.00	40.00
OTHER LAB SERVICES	1,643.84	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	199,073.38	33,685.67
MRI SERVICES	57,982.21	2,149.42

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,828.01	1,581.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,598.34

TOTAL ANCILLARY	1,136,824.59	92,342.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,136,824.59	92,342.20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,553.64	ADJUSTMENTS	0.00
COVERED CHARGES	6,424.54	CONTRACTUAL ALLOW	688.28
NON-COVERED CHARGES	1,129.10	TOTAL MEDICAID LIAB	5,736.26
		LESS: COB	5,733.26
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	323.65-
		FEE SCHEDULE-LAB	302.38
		INJECTABLE DRUGS	21.27

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	340.35	33.00
MED/SURG SUPPLY	50.17	0.00
LABORATORY-GENERAL	51.00	175.80
RADIOLOGY-DIAGNOSTIC	522.21	0.00
CT SCAN	1,438.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,097.43	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	132.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	88.43	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	759.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,668.85	161.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,424.54	1,129.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,424.54	1,129.10

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	103,109.11	ADJUSTMENTS	244.00
COVERED CHARGES	99,822.75	CONTRACTUAL ALLOW	79,172.75
NON-COVERED CHARGES	3,286.36	TOTAL MEDICAID LIAB	20,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	486.00
		REIMBURSEMENT	20,164.00

TOTAL NUMBER OF CLAIMS 413

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,220.70	16.45
MED/SURG SUPPLY	3,071.62	0.00
LABORATORY-GENERAL	13,150.08	1,454.01
RADIOLOGY-DIAGNOSTIC	4,776.31	110.50
CT SCAN	752.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,047.69	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,771.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	1,237.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	65,365.20	0.00
RECOVERY ROOM	585.00	0.00
LABORATORY PATHOLOGIC	57.49	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	662.74	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	45.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	970.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,074.71	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	317.96	387.58
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	35.22

TOTAL ANCILLARY	99,822.75	3,286.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,822.75	3,286.36

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,255.84	ADJUSTMENTS	0.00
COVERED CHARGES	2,228.98	CONTRACTUAL ALLOW	1,033.76
NON-COVERED CHARGES	26.86	TOTAL MEDICAID LIAB	1,195.22
		LESS: COB	1,192.22
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77.05	0.00
MED/SURG SUPPLY	48.20	0.00
LABORATORY-GENERAL	252.65	24.96
RADIOLOGY-DIAGNOSTIC	441.08	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,402.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7.60	1.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,228.98	26.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,228.98	26.86

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	190,708.56	ADJUSTMENTS	0.00
COVERED CHARGES	152,270.62	CONTRACTUAL ALLOW	2,182.92-
NON-COVERED CHARGES	38,437.94	TOTAL MEDICAID LIAB	154,453.54
		LESS: COB	2,951.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	151,502.42

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	37	65	12,950.00	22,750.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	37	67	12,950.00	22,750.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	7	0	4,795.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	4,795.00	0.00
TOTAL ACCOMODATIONS	44	67	17,745.00	22,750.00

INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
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FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,536.64	0.00
MED/SURG SUPPLY	8,334.92	0.00
LABORATORY-GENERAL	39,180.38	66.24
RADIOLOGY-DIAGNOSTIC	6,396.72	0.00
CT SCAN	7,760.00	0.00
PHYSICAL THERAPY	345.00	0.00
EKG/ECG	14,631.74	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,771.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,316.24	0.00
ANESTHESIA	0.00	618.80
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,354.20	0.00
RECOVERY ROOM	585.00	0.00
LABORATORY PATHOLOGIC	235.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	108.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	679.67	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	7,289.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	196.74	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	769.69	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	951.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,074.71	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,605.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,405.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	134,525.62	15,687.94
TOTAL ACCOMODATIONS	17,745.00	22,750.00
TOTAL CHARGES	152,270.62	38,437.94

ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	750,769.17	ADJUSTMENTS	3,124.21
COVERED CHARGES	696,227.82	CONTRACTUAL ALLOW	324,893.47
NON-COVERED CHARGES	54,541.35	TOTAL MEDICAID LIAB	371,334.35
		LESS: COB	751.36
		LESS: COPAYMENT	1,059.00
		REIMBURSEMENT	369,523.99
		ALL OTHER	344,240.97
		FEE SCHEDULE-LAB	22,977.76
		INJECTABLE DRUGS	2,305.26

TOTAL NUMBER OF CLAIMS 2,121

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,887.66	14.30
MED/SURG SUPPLY	17,121.30	0.00
LABORATORY-GENERAL	0.00	6,090.97
RADIOLOGY-DIAGNOSTIC	84,720.78	433.55
CT SCAN	57,464.00	3,048.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,594.83	1,164.00
IV THERAPY	0.00	0.00
OPERATING ROOM	20,598.50	1,771.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,250.88	104.24
ANESTHESIA	0.00	14,232.40
GI SERVICES	0.00	0.00
EMERGENCY ROOM	300,867.37	644.20
RECOVERY ROOM	8,190.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,288.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,332.28	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,846.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	590.22	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,078.76	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,090.00	100.00
OTHER LAB SERVICES	2,434.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	114,025.43	22,379.09
MRI SERVICES	12,896.52	1,074.71

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,796.77	3.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	634.80

TOTAL ANCILLARY	696,227.82	54,541.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	696,227.82	54,541.35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,667.67	ADJUSTMENTS	0.00
COVERED CHARGES	1,642.71	CONTRACTUAL ALLOW	505.39
NON-COVERED CHARGES	24.96	TOTAL MEDICAID LIAB	1,137.32
		LESS: COB	1,134.32
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	86.68-
		FEE SCHEDULE-LAB	85.56
		INJECTABLE DRUGS	1.12

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52.40	0.00
MED/SURG SUPPLY	18.45	0.00
LABORATORY-GENERAL	0.00	12.48
RADIOLOGY-DIAGNOSTIC	178.94	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	926.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	464.82	12.48
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,642.71	24.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,642.71	24.96

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	134,546.66	ADJUSTMENTS	338.00
COVERED CHARGES	133,201.28	CONTRACTUAL ALLOW	100,951.28
NON-COVERED CHARGES	1,345.38	TOTAL MEDICAID LIAB	32,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	864.00
		REIMBURSEMENT	31,386.00

TOTAL NUMBER OF CLAIMS 645

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,259.16	0.00
MED/SURG SUPPLY	1,027.11	0.00
LABORATORY-GENERAL	15,263.37	1,218.38
RADIOLOGY-DIAGNOSTIC	8,076.08	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	291.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	101,104.70	82.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	45.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,179.86	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	133,201.28	1,345.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	133,201.28	1,345.38

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	707.25	ADJUSTMENTS	0.00
COVERED CHARGES	707.25	CONTRACTUAL ALLOW	497.72
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	209.53
		LESS: COB	206.53
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124.85	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	571.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	707.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	707.25	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,548.99	ADJUSTMENTS	0.00
COVERED CHARGES	5,989.51	CONTRACTUAL ALLOW	2,675.60
NON-COVERED CHARGES	1,559.48	TOTAL MEDICAID LIAB	3,313.91
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	3,307.91

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP141

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	867.46	0.00
MED/SURG SUPPLY	2,084.85	0.00
LABORATORY-GENERAL	0.00	12.48
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,183.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	1,547.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	585.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	263.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,989.51	1,559.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,989.51	1,559.48

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR., DR.
FORSYTH GA 31029-1682

PROVIDER NUMBER 000001361A
NUMBER OF BEDS 30
TITLE XVIII NO: HOSP141

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	84,573.00	ADJUSTMENTS	15,761.97
COVERED CHARGES	84,182.00	CONTRACTUAL ALLOW	13,641.42
NON-COVERED CHARGES	391.00	TOTAL MEDICAID LIAB	70,540.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	70,540.58

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	55	0	25,410.00	391.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	55	0	25,410.00	391.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	55	0	25,410.00	391.00

INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,946.00	0.00
MED/SURG SUPPLY	4,839.00	0.00
LABORATORY-GENERAL	19,200.00	0.00
RADIOLOGY-DIAGNOSTIC	2,520.50	0.00
CT SCAN	1,310.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	767.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,206.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,443.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	800.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,722.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	58,772.00	0.00
TOTAL ACCOMODATIONS	25,410.00	391.00
TOTAL CHARGES	84,182.00	391.00

ZERO PAID INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	930,666.50	ADJUSTMENTS	52,280.00
COVERED CHARGES	867,447.90	CONTRACTUAL ALLOW	311,430.54
NON-COVERED CHARGES	63,218.60	TOTAL MEDICAID LIAB	556,017.36
		LESS: COB	4,960.05
		LESS: COPAYMENT	1,005.00
		REIMBURSEMENT	550,052.31
		ALL OTHER	525,925.05
		FEE SCHEDULE-LAB	24,127.26
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,840

OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,082.00	577.00
MED/SURG SUPPLY	46,167.50	666.00
LABORATORY-GENERAL	436.00	1,836.00
RADIOLOGY-DIAGNOSTIC	87,664.00	1,408.00
CT SCAN	119,872.00	0.00
PHYSICAL THERAPY	5,976.00	0.00
EKG/ECG	13,385.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,395.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,955.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	182,492.00	0.00
RECOVERY ROOM	693.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,994.00	414.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,600.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,923.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,226.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,462.50	140.00
OTHER LAB SERVICES	7,862.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	216,486.40	56,262.60
MRI SERVICES	32,373.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	315.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	867,447.90	63,218.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	867,447.90	63,218.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,081.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,378.80	CONTRACTUAL ALLOW	3,249.71
NON-COVERED CHARGES	2,702.20	TOTAL MEDICAID LIAB	3,129.09
		LESS: COB	3,117.09
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	512.46-
		FEE SCHEDULE-LAB	512.46
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.50	0.00
MED/SURG SUPPLY	555.50	0.00
LABORATORY-GENERAL	0.00	292.00
RADIOLOGY-DIAGNOSTIC	267.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	206.50	211.50
EKG/ECG	150.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	816.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	534.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,769.30	2,198.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,378.80	2,702.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,378.80	2,702.20

OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,489.00	ADJUSTMENTS	397.00
COVERED CHARGES	20,356.50	CONTRACTUAL ALLOW	14,306.50
NON-COVERED CHARGES	132.50	TOTAL MEDICAID LIAB	6,050.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	5,978.00

TOTAL NUMBER OF CLAIMS 121

OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
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1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,085.50	0.00
MED/SURG SUPPLY	559.50	0.00
LABORATORY-GENERAL	3,203.00	132.50
RADIOLOGY-DIAGNOSTIC	393.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	153.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,798.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	164.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	20,356.50	132.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,356.50	132.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	427.00	ADJUSTMENTS	0.00
COVERED CHARGES	427.00	CONTRACTUAL ALLOW	299.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	127.50
		LESS: COB	124.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.00	0.00
MED/SURG SUPPLY	8.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	231.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	427.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	427.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,330.50	ADJUSTMENTS	0.00
COVERED CHARGES	18,699.50	CONTRACTUAL ALLOW	10,403.84
NON-COVERED CHARGES	631.00	TOTAL MEDICAID LIAB	8,295.66
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	8,292.66

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,527.50	0.00
MED/SURG SUPPLY	1,345.00	0.00
LABORATORY-GENERAL	0.00	89.50
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	4,095.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	203.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	943.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,585.50	541.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,699.50	631.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,699.50	631.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	88,958.75	ADJUSTMENTS	15,566.44
COVERED CHARGES	86,775.75	CONTRACTUAL ALLOW	16,159.36
NON-COVERED CHARGES	2,183.00	TOTAL MEDICAID LIAB	70,616.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	70,616.39

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	50	0	23,150.00	2,092.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	50	0	23,150.00	2,092.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	50	0	23,150.00	2,092.00

INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,021.00	0.00
MED/SURG SUPPLY	4,725.00	0.00
LABORATORY-GENERAL	18,460.00	0.00
RADIOLOGY-DIAGNOSTIC	4,422.00	0.00
CT SCAN	7,200.00	0.00
PHYSICAL THERAPY	1,040.00	0.00
EKG/ECG	759.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	38.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,955.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	759.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,546.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	177.00	91.00
OTHER LAB SERVICES	523.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	63,625.75	91.00
TOTAL ACCOMODATIONS	23,150.00	2,092.00
TOTAL CHARGES	86,775.75	2,183.00

ZERO PAID INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	957,137.75	ADJUSTMENTS	20,664.73
COVERED CHARGES	889,246.25	CONTRACTUAL ALLOW	297,008.87
NON-COVERED CHARGES	67,891.50	TOTAL MEDICAID LIAB	592,237.38
		LESS: COB	3,909.15
		LESS: COPAYMENT	1,053.00
		REIMBURSEMENT	587,275.23
		ALL OTHER	566,611.35
		FEE SCHEDULE-LAB	20,663.88
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,745

OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,834.50	261.00
MED/SURG SUPPLY	40,156.00	836.00
LABORATORY-GENERAL	0.00	1,777.75
RADIOLOGY-DIAGNOSTIC	147,037.00	2,240.00
CT SCAN	99,983.00	23,684.00
PHYSICAL THERAPY	9,033.00	231.00
EKG/ECG	10,878.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,615.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,608.00	0.00
EMERGENCY ROOM	226,261.50	0.00
RECOVERY ROOM	400.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,343.00	0.00
SPEECH PATHOLOGY	4,725.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,342.50	550.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,045.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	351.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,325.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,406.00	497.00
OTHER LAB SERVICES	4,002.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	185,595.75	34,262.75
MRI SERVICES	31,350.00	2,200.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	307.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	889,246.25	67,891.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	889,246.25	67,891.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,926.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,488.50	CONTRACTUAL ALLOW	1,012.74
NON-COVERED CHARGES	438.00	TOTAL MEDICAID LIAB	3,475.76
		LESS: COB	3,475.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	184.51-
		FEE SCHEDULE-LAB	184.51
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.50	0.00
MED/SURG SUPPLY	280.00	22.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,079.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	135.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	38.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,184.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,577.00	416.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,488.50	438.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,488.50	438.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	67,036.50	ADJUSTMENTS	150.00
COVERED CHARGES	66,539.50	CONTRACTUAL ALLOW	51,389.50
NON-COVERED CHARGES	497.00	TOTAL MEDICAID LIAB	15,150.00
		LESS: COB	30.61
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	14,876.39

TOTAL NUMBER OF CLAIMS 303

OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,719.50	0.00
MED/SURG SUPPLY	1,744.00	59.00
LABORATORY-GENERAL	7,991.00	45.00
RADIOLOGY-DIAGNOSTIC	2,454.00	0.00
CT SCAN	1,900.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	159.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	114.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	40,340.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	918.00	393.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,200.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	66,539.50	497.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,539.50	497.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	55,465.50	ADJUSTMENTS	3,550.54
COVERED CHARGES	53,927.50	CONTRACTUAL ALLOW	20,778.06
NON-COVERED CHARGES	1,538.00	TOTAL MEDICAID LIAB	33,149.44
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	33,086.44

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,395.50	0.00
MED/SURG SUPPLY	1,196.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	864.00	0.00
CT SCAN	12,783.00	0.00
PHYSICAL THERAPY	5,014.00	0.00
EKG/ECG	450.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,237.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,929.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,759.00	1,538.00
MRI SERVICES	12,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	53,927.50	1,538.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,927.50	1,538.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSP AUTH
DBA MORGAN MEMORIAL HOSPITAL
1077 SOUTH MAIN ST
MADISON GA 30650-2073

PROVIDER NUMBER 000694229A
NUMBER OF BEDS 26
TITLE XVIII NO: CN452693

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,316,192.76	ADJUSTMENTS	27,728.42
COVERED CHARGES	5,192,910.26	CONTRACTUAL ALLOW	3,357,873.46
NON-COVERED CHARGES	123,282.50	TOTAL MEDICAID LIAB	1,835,036.80
		LESS: COB	5,767.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,829,268.90

TOTAL NUMBER OF ADMISSIONS 573

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,016	0	582,166.50	103,650.00
NURSERY CARE CHARGES	361	0	114,740.00	2,392.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	1,377	1	696,906.50	106,042.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	77	0	124,025.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	77	0	124,025.00	0.00
TOTAL ACCOMODATIONS	1,454	1	820,931.50	106,042.00

INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	616,628.30	0.00
MED/SURG SUPPLY	138,724.35	20.00
LABORATORY-GENERAL	502,141.25	0.00
RADIOLOGY-DIAGNOSTIC	78,238.00	0.00
CT SCAN	174,982.00	0.00
PHYSICAL THERAPY	11,665.00	0.00
EKG/ECG	23,497.90	0.00
IV THERAPY	461,803.00	0.00
OPERATING ROOM	511,737.70	0.00
LABOR/DELIVERY ROOM	543,502.00	0.00
RESPIRATORY SERVICES	163,636.50	0.00
ANESTHESIA	109,954.00	583.00
GI SERVICES	33,040.00	0.00
EMERGENCY ROOM	100,978.00	0.00
RECOVERY ROOM	333,895.95	0.00
LABORATORY PATHOLOGIC	750.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,192.00	0.00
SPEECH PATHOLOGY	2,102.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	35,662.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	49,976.00	3,928.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	34,378.00	0.00
AUDIOLOGY	1,740.75	8,684.00
CARDIOLOGY	29,599.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,460.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	178,911.18	0.00
OTHER LAB SERVICES	13,205.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	40,446.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	174,132.28	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,025.50

TOTAL ANCILLARY	4,371,978.76	17,240.50
TOTAL ACCOMODATIONS	820,931.50	106,042.00
TOTAL CHARGES	5,192,910.26	123,282.50

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	71,444.25	ADJUSTMENTS	0.00
COVERED CHARGES	69,588.25	CONTRACTUAL ALLOW	13,100.96
NON-COVERED CHARGES	1,856.00	TOTAL MEDICAID LIAB	56,487.29
		LESS: COB	56,487.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	27	0	14,193.00	1,800.00
NURSERY CARE CHARGES	2	0	620.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	14,813.00	1,800.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	29	0	14,813.00	1,800.00

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,917.30	0.00
MED/SURG SUPPLY	1,329.00	0.00
LABORATORY-GENERAL	4,047.00	0.00
RADIOLOGY-DIAGNOSTIC	726.00	0.00
CT SCAN	1,865.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	94.00	0.00
IV THERAPY	12,400.00	0.00
OPERATING ROOM	2,244.00	0.00
LABOR/DELIVERY ROOM	10,752.00	0.00
RESPIRATORY SERVICES	2,143.00	0.00
ANESTHESIA	572.00	0.00
GI SERVICES	4,641.00	0.00
EMERGENCY ROOM	1,029.00	0.00
RECOVERY ROOM	4,944.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	56.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,071.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	54,775.25	56.00
TOTAL ACCOMODATIONS	14,813.00	1,800.00
TOTAL CHARGES	69,588.25	1,856.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,356,383.51	ADJUSTMENTS	54,647.40
COVERED CHARGES	4,844,175.26	CONTRACTUAL ALLOW	3,174,137.71
NON-COVERED CHARGES	512,208.25	TOTAL MEDICAID LIAB	1,670,037.55
		LESS: COB	3,556.26
		LESS: COPAYMENT	2,901.00
		REIMBURSEMENT	1,663,580.29
		ALL OTHER	1,571,038.12
		FEE SCHEDULE-LAB	81,142.23
		INJECTABLE DRUGS	11,399.94

TOTAL NUMBER OF CLAIMS 4,199

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	238,351.38	4,994.96
MED/SURG SUPPLY	64,280.44	4,974.15
LABORATORY-GENERAL	714.00	6,700.00
RADIOLOGY-DIAGNOSTIC	441,204.00	5,395.00
CT SCAN	529,938.00	84,432.00
PHYSICAL THERAPY	13,563.00	567.00
EKG/ECG	41,780.30	594.00
IV THERAPY	123,194.00	868.00
OPERATING ROOM	507,282.00	94,345.00
LABOR/DELIVERY ROOM	230,982.00	179.00
RESPIRATORY SERVICES	31,385.75	145.00
ANESTHESIA	98,629.00	1,166.00
GI SERVICES	123,294.00	9,751.00
EMERGENCY ROOM	837,920.00	51,793.00
RECOVERY ROOM	181,842.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	165,596.00	5,689.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,720.00	4,487.00
ONCOLOGY	550.00	0.00
NUCLEAR MEDICINE	65,926.00	3,581.00
AUDIOLOGY	55.00	0.00
CARDIOLOGY	41,869.55	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,440.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	110,070.43	52,599.69
OTHER LAB SERVICES	25,791.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	916.00	0.00
OTHER THERAPEUTIC SERVI	127.40	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	748,824.95	121,760.50
MRI SERVICES	183,279.00	12,272.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	29,650.06	43,536.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	6.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	902.00

TOTAL ANCILLARY	4,844,175.26	510,738.25
TOTAL ACCOMODATIONS	0.00	1,470.00
TOTAL CHARGES	4,844,175.26	512,208.25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	41,754.55	ADJUSTMENTS	0.00
COVERED CHARGES	33,310.55	CONTRACTUAL ALLOW	9,213.17
NON-COVERED CHARGES	8,444.00	TOTAL MEDICAID LIAB	24,097.38
		LESS: COB	24,076.38
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	636.28-
		FEE SCHEDULE-LAB	591.17
		INJECTABLE DRUGS	45.11

TOTAL NUMBER OF CLAIMS 37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,277.20	87.00
MED/SURG SUPPLY	193.75	0.00
LABORATORY-GENERAL	0.00	19.00
RADIOLOGY-DIAGNOSTIC	3,830.00	0.00
CT SCAN	0.00	6,000.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	194.00	0.00
IV THERAPY	890.00	0.00
OPERATING ROOM	4,333.00	0.00
LABOR/DELIVERY ROOM	4,535.00	0.00
RESPIRATORY SERVICES	110.00	0.00
ANESTHESIA	1,001.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,202.00	240.00
RECOVERY ROOM	1,167.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,172.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	863.75	831.00
OTHER LAB SERVICES	59.00	60.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	75.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,248.60	781.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	159.25	426.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,310.55	8,444.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,310.55	8,444.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	152,440.28	ADJUSTMENTS	200.00
COVERED CHARGES	150,013.28	CONTRACTUAL ALLOW	132,163.28
NON-COVERED CHARGES	2,427.00	TOTAL MEDICAID LIAB	17,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	17,523.00

TOTAL NUMBER OF CLAIMS 357

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,556.43	0.00
MED/SURG SUPPLY	265.50	0.00
LABORATORY-GENERAL	29,939.95	1,884.00
RADIOLOGY-DIAGNOSTIC	12,912.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	541.10	0.00
IV THERAPY	2,033.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,398.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	88,233.00	423.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	223.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,301.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,597.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,013.30	120.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	150,013.28	2,427.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	150,013.28	2,427.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	42,893.40	ADJUSTMENTS	0.00
COVERED CHARGES	32,847.40	CONTRACTUAL ALLOW	32,634.90
NON-COVERED CHARGES	10,046.00	TOTAL MEDICAID LIAB	212.50
		LESS: COB	212.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 57

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,079.80	122.00
MED/SURG SUPPLY	54.00	0.00
LABORATORY-GENERAL	5,324.00	171.00
RADIOLOGY-DIAGNOSTIC	5,257.00	0.00
CT SCAN	1,617.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	396.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	259.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,793.00	9,633.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	67.60	120.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	32,847.40	10,046.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,847.40	10,046.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,034,235.99	ADJUSTMENTS	17,457.65
COVERED CHARGES	993,379.11	CONTRACTUAL ALLOW	704,376.97
NON-COVERED CHARGES	40,856.88	TOTAL MEDICAID LIAB	289,002.14
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	288,828.14

TOTAL NUMBER OF CLAIMS 82

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 11U225

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,718.55	1,703.46
MED/SURG SUPPLY	114,873.09	250.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,619.00	1,174.00
CT SCAN	27,449.00	10,364.00
PHYSICAL THERAPY	246.00	307.00
EKG/ECG	6,640.00	392.00
IV THERAPY	24,940.00	0.00
OPERATING ROOM	470,255.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,004.50	0.00
ANESTHESIA	70,212.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,961.00	2,870.00
RECOVERY ROOM	91,370.00	654.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,075.00	492.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,168.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,459.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,292.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,587.42	6,916.12
OTHER LAB SERVICES	1,061.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,021.00	8,707.00
MRI SERVICES	17,422.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,005.55	6,710.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	317.00

TOTAL ANCILLARY	993,379.11	40,856.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	993,379.11	40,856.88

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE MEDICAL CTR
1266 HWY 515 SOUTH
JASPER GA 30143-4872

PROVIDER NUMBER 000001493A
NUMBER OF BEDS 35
TITLE XVIII NO: 11U225

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	73,893.02	ADJUSTMENTS	0.00
COVERED CHARGES	69,137.02	CONTRACTUAL ALLOW	10,255.29
NON-COVERED CHARGES	4,756.00	TOTAL MEDICAID LIAB	58,881.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	58,881.73

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	45	0	15,745.00	1,987.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	45	0	15,745.00	1,987.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	45	0	15,745.00	1,987.00

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,857.12	0.00
MED/SURG SUPPLY	4,210.00	0.00
LABORATORY-GENERAL	12,121.00	0.00
RADIOLOGY-DIAGNOSTIC	1,828.00	0.00
CT SCAN	4,136.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	564.00	0.00
IV THERAPY	5,149.50	0.00
OPERATING ROOM	1,371.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,290.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,542.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,769.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	95.00	0.00
OTHER LAB SERVICES	1,122.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	106.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	53,392.02	2,769.00
TOTAL ACCOMODATIONS	15,745.00	1,987.00
TOTAL CHARGES	69,137.02	4,756.00

ZERO PAID INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	190,160.45	ADJUSTMENTS	68.91
COVERED CHARGES	179,139.45	CONTRACTUAL ALLOW	82,213.86
NON-COVERED CHARGES	11,021.00	TOTAL MEDICAID LIAB	96,925.59
		LESS: COB	388.17
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	96,279.42
		ALL OTHER	89,057.46
		FEE SCHEDULE-LAB	6,253.88
		INJECTABLE DRUGS	968.08

TOTAL NUMBER OF CLAIMS 394

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,401.55	0.00
MED/SURG SUPPLY	8,545.00	63.00
LABORATORY-GENERAL	0.00	2,379.00
RADIOLOGY-DIAGNOSTIC	21,165.00	114.00
CT SCAN	45,660.00	941.00
PHYSICAL THERAPY	1,752.00	864.00
EKG/ECG	2,144.00	0.00
IV THERAPY	1,699.50	0.00
OPERATING ROOM	2,718.50	608.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,942.00	0.00
ANESTHESIA	2,024.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,457.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	144.00
SPEECH PATHOLOGY	419.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	718.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,556.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	666.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,511.00	0.00
OTHER LAB SERVICES	1,252.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,534.50	5,236.00
MRI SERVICES	1,078.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	6.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,561.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	179,139.45	11,021.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	179,139.45	11,021.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,970.19	ADJUSTMENTS	0.00
COVERED CHARGES	2,277.19	CONTRACTUAL ALLOW	8.76
NON-COVERED CHARGES	693.00	TOTAL MEDICAID LIAB	2,268.43
		LESS: COB	2,262.43
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	74.31-
		FEE SCHEDULE-LAB	74.31
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.54	0.00
MED/SURG SUPPLY	76.00	0.00
LABORATORY-GENERAL	0.00	31.00
RADIOLOGY-DIAGNOSTIC	336.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	564.00	576.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	86.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	527.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	276.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	439.65	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,277.19	693.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,277.19	693.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,738.09	ADJUSTMENTS	100.00
COVERED CHARGES	14,384.09	CONTRACTUAL ALLOW	11,084.09
NON-COVERED CHARGES	354.00	TOTAL MEDICAID LIAB	3,300.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,300.00

TOTAL NUMBER OF CLAIMS 66

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,573.44	0.00
MED/SURG SUPPLY	357.50	0.00
LABORATORY-GENERAL	2,659.00	354.00
RADIOLOGY-DIAGNOSTIC	1,676.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	80.00	0.00
IV THERAPY	198.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	229.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,036.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	322.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	163.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,384.09	354.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,384.09	354.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	192.00	ADJUSTMENTS	0.00
COVERED CHARGES	192.00	CONTRACTUAL ALLOW	134.84
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	57.16
		LESS: COB	54.16
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21.50	0.00
MED/SURG SUPPLY	33.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	12.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	192.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	192.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	112,583.24	ADJUSTMENTS	4,851.00
COVERED CHARGES	107,683.43	CONTRACTUAL ALLOW	5,726.98-
NON-COVERED CHARGES	4,899.81	TOTAL MEDICAID LIAB	113,410.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	113,410.41

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	75	0	26,475.00	2,413.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	75	0	26,475.00	2,413.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	75	0	26,475.00	2,413.00

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,108.68	0.00
MED/SURG SUPPLY	5,409.00	0.00
LABORATORY-GENERAL	28,698.25	0.00
RADIOLOGY-DIAGNOSTIC	2,171.00	0.00
CT SCAN	9,687.00	0.00
PHYSICAL THERAPY	780.00	0.00
EKG/ECG	1,064.00	0.00
IV THERAPY	5,488.50	0.00
OPERATING ROOM	1,446.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,298.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	671.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,196.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,490.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	191.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	996.81

TOTAL ANCILLARY	81,208.43	2,486.81
TOTAL ACCOMODATIONS	26,475.00	2,413.00
TOTAL CHARGES	107,683.43	4,899.81

ZERO PAID INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	647,641.08	ADJUSTMENTS	6,735.29
COVERED CHARGES	608,720.48	CONTRACTUAL ALLOW	288,487.81
NON-COVERED CHARGES	38,920.60	TOTAL MEDICAID LIAB	320,232.67
		LESS: COB	219.75
		LESS: COPAYMENT	507.00
		REIMBURSEMENT	319,505.92
		ALL OTHER	300,856.86
		FEE SCHEDULE-LAB	18,554.26
		INJECTABLE DRUGS	94.80

TOTAL NUMBER OF CLAIMS 1,154

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,295.41	403.20
MED/SURG SUPPLY	23,043.95	0.00
LABORATORY-GENERAL	132.00	4,636.95
RADIOLOGY-DIAGNOSTIC	68,315.00	442.00
CT SCAN	103,274.00	0.00
PHYSICAL THERAPY	1,704.00	0.00
EKG/ECG	8,708.00	0.00
IV THERAPY	7,749.50	0.00
OPERATING ROOM	8,260.00	1,053.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,241.00	98.00
ANESTHESIA	5,005.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	168,943.25	2,118.85
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	480.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,840.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,219.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,049.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,435.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,985.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,359.20	100.00
OTHER LAB SERVICES	1,122.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	180.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	132,278.15	28,181.35
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	6.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	151.02	31.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	80.45

TOTAL ANCILLARY	608,720.48	38,200.60
TOTAL ACCOMODATIONS	0.00	720.00
TOTAL CHARGES	608,720.48	38,920.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,186.85	ADJUSTMENTS	0.00
COVERED CHARGES	3,832.85	CONTRACTUAL ALLOW	1,701.41
NON-COVERED CHARGES	354.00	TOTAL MEDICAID LIAB	2,131.44
		LESS: COB	2,119.44
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	311.06-
		FEE SCHEDULE-LAB	311.06
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124.85	0.00
MED/SURG SUPPLY	55.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	418.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	84.00	0.00
IV THERAPY	24.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	815.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11.00	0.00
OTHER LAB SERVICES	563.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,704.50	354.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,832.85	354.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,832.85	354.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	55,011.78	ADJUSTMENTS	197.00
COVERED CHARGES	53,324.88	CONTRACTUAL ALLOW	45,324.88
NON-COVERED CHARGES	1,686.90	TOTAL MEDICAID LIAB	8,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	7,877.00

TOTAL NUMBER OF CLAIMS 160

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,286.70	0.00
MED/SURG SUPPLY	1,700.00	0.00
LABORATORY-GENERAL	7,653.55	845.70
RADIOLOGY-DIAGNOSTIC	4,982.00	184.00
CT SCAN	1,910.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	364.00	0.00
IV THERAPY	395.50	0.00
OPERATING ROOM	0.00	253.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,283.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,779.83	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	351.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	949.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	53.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	53,324.88	1,686.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,324.88	1,686.90

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,824.25	ADJUSTMENTS	0.00
COVERED CHARGES	737.25	CONTRACTUAL ALLOW	287.75
NON-COVERED CHARGES	1,087.00	TOTAL MEDICAID LIAB	449.50
		LESS: COB	449.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165.25	0.00
MED/SURG SUPPLY	20.00	0.00
LABORATORY-GENERAL	37.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	140.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	342.00	1,087.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	737.25	1,087.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	737.25	1,087.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,634.05	ADJUSTMENTS	0.00
COVERED CHARGES	6,634.05	CONTRACTUAL ALLOW	2,676.01
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,958.04
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,955.04

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	326.05	0.00
MED/SURG SUPPLY	2,831.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,315.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,162.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,634.05	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,634.05	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,372.87	ADJUSTMENTS	0.00
COVERED CHARGES	4,351.87	CONTRACTUAL ALLOW	976.08-
NON-COVERED CHARGES	21.00	TOTAL MEDICAID LIAB	5,327.95
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,327.95

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	1,059.00	21.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,059.00	21.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,059.00	21.00

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	765.87	0.00
MED/SURG SUPPLY	31.50	0.00
LABORATORY-GENERAL	1,260.00	0.00
RADIOLOGY-DIAGNOSTIC	368.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	337.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	530.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,292.87	0.00
TOTAL ACCOMODATIONS	1,059.00	21.00
TOTAL CHARGES	4,351.87	21.00

ZERO PAID INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	56,631.76	ADJUSTMENTS	146.53
COVERED CHARGES	53,284.46	CONTRACTUAL ALLOW	23,384.95
NON-COVERED CHARGES	3,347.30	TOTAL MEDICAID LIAB	29,899.51
		LESS: COB	61.95
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	29,798.56
		ALL OTHER	28,040.70
		FEE SCHEDULE-LAB	1,742.85
		INJECTABLE DRUGS	15.01

TOTAL NUMBER OF CLAIMS 95

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,623.26	0.00
MED/SURG SUPPLY	1,590.00	0.00
LABORATORY-GENERAL	0.00	287.00
RADIOLOGY-DIAGNOSTIC	4,729.00	0.00
CT SCAN	8,736.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,120.00	0.00
IV THERAPY	622.50	0.00
OPERATING ROOM	0.00	113.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,016.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,629.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	35.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	925.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,985.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	909.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,342.90	2,947.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	53,284.46	3,347.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,284.46	3,347.30

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,861.10	ADJUSTMENTS	0.00
COVERED CHARGES	6,781.10	CONTRACTUAL ALLOW	5,831.10
NON-COVERED CHARGES	80.00	TOTAL MEDICAID LIAB	950.00
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	935.00

TOTAL NUMBER OF CLAIMS 19

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	662.20	0.00
MED/SURG SUPPLY	186.50	0.00
LABORATORY-GENERAL	1,540.40	80.00
RADIOLOGY-DIAGNOSTIC	223.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	132.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,949.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	88.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,781.10	80.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,781.10	80.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	10,899.70	ADJUSTMENTS	0.00
COVERED CHARGES	10,883.70	CONTRACTUAL ALLOW	6,925.66
NON-COVERED CHARGES	16.00	TOTAL MEDICAID LIAB	3,958.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,958.04

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,695.00	0.00
MED/SURG SUPPLY	94.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	70.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	842.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	148.70	16.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,883.70	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,883.70	16.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 07/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	147,622.02	ADJUSTMENTS	0.00
COVERED CHARGES	145,734.02	CONTRACTUAL ALLOW	39,496.79
NON-COVERED CHARGES	1,888.00	TOTAL MEDICAID LIAB	106,237.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	106,237.23

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	89	0	31,092.00	1,888.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	89	0	31,092.00	1,888.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	89	0	31,092.00	1,888.00

INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,069.72	0.00
MED/SURG SUPPLY	11,339.50	0.00
LABORATORY-GENERAL	32,076.50	0.00
RADIOLOGY-DIAGNOSTIC	1,365.00	0.00
CT SCAN	5,873.00	0.00
PHYSICAL THERAPY	696.00	0.00
EKG/ECG	840.00	0.00
IV THERAPY	7,085.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,578.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	184.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,375.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	471.30	0.00
OTHER LAB SERVICES	689.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	114,642.02	0.00
TOTAL ACCOMODATIONS	31,092.00	1,888.00
TOTAL CHARGES	145,734.02	1,888.00

ZERO PAID INPATIENT PAID CLAIMS

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	701,889.60	ADJUSTMENTS	6,040.93
COVERED CHARGES	626,489.07	CONTRACTUAL ALLOW	279,415.40
NON-COVERED CHARGES	75,400.53	TOTAL MEDICAID LIAB	347,073.67
		LESS: COB	477.45
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	345,987.22
		ALL OTHER	327,671.23
		FEE SCHEDULE-LAB	18,152.75
		INJECTABLE DRUGS	163.24

TOTAL NUMBER OF CLAIMS 1,189

OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,991.81	0.00
MED/SURG SUPPLY	29,867.00	198.00
LABORATORY-GENERAL	0.00	2,550.00
RADIOLOGY-DIAGNOSTIC	83,802.00	1,118.00
CT SCAN	71,762.00	21,667.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,770.00	0.00
IV THERAPY	19,012.50	0.00
OPERATING ROOM	7,139.00	5,269.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,161.46	16.38
ANESTHESIA	5,283.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	174,730.95	6,717.80
RECOVERY ROOM	3,307.50	202.50
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,475.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,931.00	479.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,404.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,220.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,487.00	1,535.30
OTHER LAB SERVICES	2,248.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	60.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	149,009.25	33,163.55
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	231.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	626,489.07	74,320.53
TOTAL ACCOMODATIONS	0.00	1,080.00
TOTAL CHARGES	626,489.07	75,400.53

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,244.60	ADJUSTMENTS	0.00
COVERED CHARGES	2,228.60	CONTRACTUAL ALLOW	469.68
NON-COVERED CHARGES	16.00	TOTAL MEDICAID LIAB	1,758.92
		LESS: COB	1,758.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	80.62-
		FEE SCHEDULE-LAB	80.62
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153.60	0.00
MED/SURG SUPPLY	78.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	280.00	0.00
IV THERAPY	251.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	789.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	567.00	16.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,228.60	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,228.60	16.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	63,955.35	ADJUSTMENTS	300.00
COVERED CHARGES	62,141.35	CONTRACTUAL ALLOW	52,208.39
NON-COVERED CHARGES	1,814.00	TOTAL MEDICAID LIAB	9,932.96
		LESS: COB	3.63
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	9,779.33

TOTAL NUMBER OF CLAIMS 198

OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,477.11	0.00
MED/SURG SUPPLY	1,022.50	0.00
LABORATORY-GENERAL	8,926.15	553.00
RADIOLOGY-DIAGNOSTIC	4,479.00	130.00
CT SCAN	988.00	1,021.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	489.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	830.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,123.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	929.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	352.00	110.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	357.90	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	167.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	62,141.35	1,814.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,141.35	1,814.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,348.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,347.65	CONTRACTUAL ALLOW	1,347.65
NON-COVERED CHARGES	2,000.65	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325.70	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	230.00	16.00
RADIOLOGY-DIAGNOSTIC	752.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	1,984.65
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,347.65	2,000.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,347.65	2,000.65

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	21,250.90	ADJUSTMENTS	0.00
COVERED CHARGES	21,234.90	CONTRACTUAL ALLOW	11,070.66
NON-COVERED CHARGES	16.00	TOTAL MEDICAID LIAB	10,164.24
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,158.24

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111336

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,073.45	0.00
MED/SURG SUPPLY	3,544.95	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,226.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	140.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	10,343.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	175.00	0.00
ANESTHESIA	2,847.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	810.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	315.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	417.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	195.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	148.00	16.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,234.90	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,234.90	16.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROF. RESOURCES MGNT. OF RABUN, LLC
196 RIDGCREST CIRCLE
CLAYTON GA 30525-4111

PROVIDER NUMBER 000001559A
NUMBER OF BEDS 26
TITLE XVIII NO: 111336

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	59,916,901.06	ADJUSTMENTS	276,648.08
COVERED CHARGES	56,129,861.27	CONTRACTUAL ALLOW	34,767,910.74
NON-COVERED CHARGES	3,787,039.79	TOTAL MEDICAID LIAB	21,361,950.53
		LESS: COB	57,803.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,304,146.54

TOTAL NUMBER OF ADMISSIONS 6,651

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	15,162	0	8,678,782.75	2,237,480.00
NURSERY CARE CHARGES	7,103	0	3,085,793.00	329,370.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	38	0.00	0.00
TOTAL ROUTINE	22,265	38	11,764,575.75	2,566,850.00
SPECIAL CARE SERVICES				
C C U	255	0	359,300.00	0.00
I C U	669	0	983,062.50	0.00
N I C U	566	0	622,726.00	0.00
PED I C U	19	0	13,608.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	311	0.00	211,110.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,509	311	1,978,696.50	211,110.00
TOTAL ACCOMODATIONS	23,774	349	13,743,272.25	2,777,960.00

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,890,709.74	672.00
MED/SURG SUPPLY	7,229,321.59	264.00
LABORATORY-GENERAL	4,728,755.83	0.00
RADIOLOGY-DIAGNOSTIC	690,291.86	0.00
CT SCAN	1,073,974.22	0.00
PHYSICAL THERAPY	231,431.22	0.00
EKG/ECG	206,444.20	0.00
IV THERAPY	852.00	0.00
OPERATING ROOM	1,968,678.16	0.00
LABOR/DELIVERY ROOM	6,205,506.00	0.00
RESPIRATORY SERVICES	3,369,601.98	0.00
ANESTHESIA	547,706.57	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	692,267.12	0.00
RECOVERY ROOM	346,020.62	0.00
LABORATORY PATHOLOGIC	112,695.61	0.00
RADIOLOGY THERAPEUTIC	63,524.18	0.00
OCCUPATIONAL THERAPY	105,190.00	0.00
SPEECH PATHOLOGY	86,388.00	0.00
RENAL DIALYSIS	123,971.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	132.00
PSYCHIATRIC SERVICES	11,000.00	6,216.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	289,577.22	437.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	357,127.74	13,285.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	140,278.80	0.00
AUDIOLOGY	136,474.64	0.00
CARDIOLOGY	1,106,187.54	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,689.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	893,824.21	777.76
OTHER LAB SERVICES	68,696.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,298.26	838.34
OTHER THERAPEUTIC SERVI	322.44	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	159,218.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	515,564.00	982,995.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,462.33

TOTAL ANCILLARY	42,386,589.02	1,009,079.79
TOTAL ACCOMODATIONS	13,743,272.25	2,777,960.00
TOTAL CHARGES	56,129,861.27	3,787,039.79

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	600,461.31	ADJUSTMENTS	0.00
COVERED CHARGES	573,949.06	CONTRACTUAL ALLOW	75,623.90
NON-COVERED CHARGES	26,512.25	TOTAL MEDICAID LIAB	498,325.16
		LESS: COB	498,325.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 87

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	211	0	113,864.00	18,623.00
NURSERY CARE CHARGES	57	0	22,105.00	1,300.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	268	0	135,969.00	19,923.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,470.00	0.00
N I C U	7	0	7,798.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	4	0.00	2,736.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8	4	9,268.00	2,736.00
TOTAL ACCOMODATIONS	276	4	145,237.00	22,659.00

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,503.24	0.00
MED/SURG SUPPLY	60,721.00	0.00
LABORATORY-GENERAL	33,048.80	0.00
RADIOLOGY-DIAGNOSTIC	3,471.80	0.00
CT SCAN	7,004.00	0.00
PHYSICAL THERAPY	1,858.00	0.00
EKG/ECG	376.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,888.15	0.00
LABOR/DELIVERY ROOM	155,844.00	0.00
RESPIRATORY SERVICES	24,086.00	0.00
ANESTHESIA	2,852.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,517.53	0.00
RECOVERY ROOM	2,944.22	0.00
LABORATORY PATHOLOGIC	1,557.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,501.00	0.00
SPEECH PATHOLOGY	1,400.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,770.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,895.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,360.00	0.00
CARDIOLOGY	1,328.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	623.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,621.88	0.00
OTHER LAB SERVICES	424.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,489.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,625.34	3,562.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	290.64

TOTAL ANCILLARY	428,712.06	3,853.25
TOTAL ACCOMODATIONS	145,237.00	22,659.00
TOTAL CHARGES	573,949.06	26,512.25

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	35,133,260.90	ADJUSTMENTS	158,337.75
COVERED CHARGES	33,328,423.10	CONTRACTUAL ALLOW	21,500,556.28
NON-COVERED CHARGES	1,804,837.80	TOTAL MEDICAID LIAB	11,827,866.82
		LESS: COB	7,993.36
		LESS: COPAYMENT	36,927.00
		REIMBURSEMENT	11,782,946.46
		ALL OTHER	10,999,368.34
		FEE SCHEDULE-LAB	783,528.35
		INJECTABLE DRUGS	49.77

TOTAL NUMBER OF CLAIMS 36,308

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,631,488.97	55,631.23
MED/SURG SUPPLY	2,838,711.89	25,276.00
LABORATORY-GENERAL	3,332.00	55,936.19
RADIOLOGY-DIAGNOSTIC	2,581,851.00	54,035.72
CT SCAN	2,997,879.47	63,253.03
PHYSICAL THERAPY	415,373.00	19,284.00
EKG/ECG	265,413.40	6,405.60
IV THERAPY	1,292.00	0.00
OPERATING ROOM	2,989,959.36	169,592.83
LABOR/DELIVERY ROOM	70,514.00	31,024.00
RESPIRATORY SERVICES	504,483.84	16,782.35
ANESTHESIA	1,113,483.47	16,980.96
GI SERVICES	4,774.80	0.00
EMERGENCY ROOM	5,439,062.49	150,288.68
RECOVERY ROOM	981,811.67	2,096.00
LABORATORY PATHOLOGIC	0.00	90.00
RADIOLOGY THERAPEUTIC	269,920.68	12,992.60
OCCUPATIONAL THERAPY	113,319.00	10,858.00
SPEECH PATHOLOGY	81,389.00	400.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,132.80	0.00
PSYCHIATRIC SERVICES	151,930.00	14,324.00
LITHOTRIPSY	38,040.00	0.00
OTHER IMAGING SERVICES	970,507.50	19,325.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,253.00	68,367.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	284,223.80	13,261.60
AUDIOLOGY	9,690.00	0.00
CARDIOLOGY	762,769.79	60,970.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	521,467.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,746,373.01	6,956.75
OTHER LAB SERVICES	109,285.40	3,688.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,814.99	21.50
OTHER THERAPEUTIC SERVI	674.99	158.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,653,875.51	763,694.32
MRI SERVICES	622,184.20	10,905.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	438.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	15,468.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	115,672.27	151,239.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	559.64

TOTAL ANCILLARY	33,328,423.10	1,804,837.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,328,423.10	1,804,837.80

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	70,426.87	ADJUSTMENTS	0.00
COVERED CHARGES	67,805.51	CONTRACTUAL ALLOW	25,482.01
NON-COVERED CHARGES	2,621.36	TOTAL MEDICAID LIAB	42,323.50
		LESS: COB	42,236.50
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,995.78-
		FEE SCHEDULE-LAB	1,995.78
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 103

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,728.12	0.00
MED/SURG SUPPLY	9,000.00	0.00
LABORATORY-GENERAL	0.00	306.40
RADIOLOGY-DIAGNOSTIC	5,458.22	0.00
CT SCAN	6,546.20	0.00
PHYSICAL THERAPY	215.00	0.00
EKG/ECG	1,135.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,165.02	0.00
LABOR/DELIVERY ROOM	160.00	0.00
RESPIRATORY SERVICES	443.00	0.00
ANESTHESIA	1,827.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,455.44	79.00
RECOVERY ROOM	1,849.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	5.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	962.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,520.20	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,604.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,351.69	0.00
OTHER LAB SERVICES	414.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,434.66	2,062.68
MRI SERVICES	1,521.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	67.20
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.56	101.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,805.51	2,621.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,805.51	2,621.36

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,539,376.32	ADJUSTMENTS	1,588.00
COVERED CHARGES	1,497,405.78	CONTRACTUAL ALLOW	1,337,355.78
NON-COVERED CHARGES	41,970.54	TOTAL MEDICAID LIAB	160,050.00
		LESS: COB	74.58
		LESS: COPAYMENT	2,964.00
		REIMBURSEMENT	157,011.42

TOTAL NUMBER OF CLAIMS 3,201

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,347.29	0.00
MED/SURG SUPPLY	67,962.98	0.00
LABORATORY-GENERAL	180,168.31	23,381.12
RADIOLOGY-DIAGNOSTIC	145,413.03	1,649.00
CT SCAN	77,581.12	0.00
PHYSICAL THERAPY	1,385.00	0.00
EKG/ECG	9,348.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,605.16	946.28
LABOR/DELIVERY ROOM	4,488.00	0.00
RESPIRATORY SERVICES	25,235.50	0.00
ANESTHESIA	817.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	782,145.54	9,624.10
RECOVERY ROOM	798.00	0.00
LABORATORY PATHOLOGIC	352.80	0.00
RADIOLOGY THERAPEUTIC	9,048.80	110.00
OCCUPATIONAL THERAPY	1,796.00	0.00
SPEECH PATHOLOGY	194.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	46,218.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,231.20	91.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	400.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	623.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,056.17	0.00
OTHER LAB SERVICES	2,622.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,149.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,418.58	6,168.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,497,405.78	41,970.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,497,405.78	41,970.54

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,600.89	ADJUSTMENTS	0.00
COVERED CHARGES	3,556.12	CONTRACTUAL ALLOW	2,845.24
NON-COVERED CHARGES	4,044.77	TOTAL MEDICAID LIAB	710.88
		LESS: COB	704.88
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230.25	78.64
MED/SURG SUPPLY	307.00	0.00
LABORATORY-GENERAL	1,089.18	559.72
RADIOLOGY-DIAGNOSTIC	318.20	107.00
CT SCAN	0.00	1,216.80
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	188.40	188.40
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10.00	60.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,399.05	1,821.05
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.04	13.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,556.12	4,044.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,556.12	4,044.77

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,504,317.17	ADJUSTMENTS	16,007.48
COVERED CHARGES	3,417,812.83	CONTRACTUAL ALLOW	2,513,272.71
NON-COVERED CHARGES	86,504.34	TOTAL MEDICAID LIAB	904,540.12
		LESS: COB	0.00
		LESS: COPAYMENT	456.00
		REIMBURSEMENT	904,084.12

TOTAL NUMBER OF CLAIMS 226

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	947,718.79	10,235.88
MED/SURG SUPPLY	588,548.37	276.00
LABORATORY-GENERAL	714.00	4,069.86
RADIOLOGY-DIAGNOSTIC	72,365.00	6,302.22
CT SCAN	111,606.05	415.00
PHYSICAL THERAPY	8,150.00	368.00
EKG/ECG	11,492.40	188.40
IV THERAPY	7,776.00	216.00
OPERATING ROOM	495,263.88	5,886.00
LABOR/DELIVERY ROOM	160.00	0.00
RESPIRATORY SERVICES	5,419.00	212.00
ANESTHESIA	150,840.24	4,112.32
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,855.37	474.00
RECOVERY ROOM	122,377.46	1,051.80
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	530,173.74	11,957.40
OCCUPATIONAL THERAPY	4,714.00	0.00
SPEECH PATHOLOGY	5,514.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,885.00	553.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	15,216.00	0.00
OTHER IMAGING SERVICES	17,388.40	906.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,473.00	9,719.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,428.00	192.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	49,400.79	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	623.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	94,045.09	1,830.66
OTHER LAB SERVICES	1,288.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	87,842.76	20,814.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,533.69	6,723.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,417,812.83	86,504.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,417,812.83	86,504.34

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
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PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,895,676.65	ADJUSTMENTS	1,148,294.44
COVERED CHARGES	65,378,501.08	CONTRACTUAL ALLOW	42,403,462.75
NON-COVERED CHARGES	2,517,175.57	TOTAL MEDICAID LIAB	22,975,038.33
		LESS: COB	68,695.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,906,342.75

TOTAL NUMBER OF ADMISSIONS 6,840

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,397	0	9,635,462.75	2,000,562.00
NURSERY CARE CHARGES	7,248	0	3,160,247.00	256,734.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	54	0.00	0.00
TOTAL ROUTINE	23,645	54	12,795,709.75	2,257,296.00
SPECIAL CARE SERVICES				
C C U	207	0	295,260.00	0.00
I C U	795	0	1,167,915.00	0.00
N I C U	567	0	629,410.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	238	0.00	160,064.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,569	238	2,092,585.00	160,064.00
TOTAL ACCOMODATIONS	25,214	292	14,888,294.75	2,417,360.00

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,128,704.49	0.00
MED/SURG SUPPLY	8,130,786.75	1,598.00
LABORATORY-GENERAL	5,665,821.34	0.00
RADIOLOGY-DIAGNOSTIC	1,582,560.86	0.00
CT SCAN	1,594,785.81	0.00
PHYSICAL THERAPY	222,380.25	0.00
EKG/ECG	240,576.29	0.00
IV THERAPY	1,400.00	0.00
OPERATING ROOM	2,313,019.88	0.00
LABOR/DELIVERY ROOM	6,520,542.18	0.00
RESPIRATORY SERVICES	3,802,577.39	0.00
ANESTHESIA	647,694.96	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	838,655.91	0.00
RECOVERY ROOM	514,550.03	0.00
LABORATORY PATHOLOGIC	153,848.10	0.00
RADIOLOGY THERAPEUTIC	39,449.59	118.80
OCCUPATIONAL THERAPY	100,134.66	0.00
SPEECH PATHOLOGY	108,054.58	0.00
RENAL DIALYSIS	202,153.87	3,886.99
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	187.00
PSYCHIATRIC SERVICES	27,000.00	4,662.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	366,111.42	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	456,032.16	15,201.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	180,009.65	0.00
AUDIOLOGY	148,847.24	0.00
CARDIOLOGY	1,115,547.92	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,464.18	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,373,165.69	281.16
OTHER LAB SERVICES	109,739.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,590.80	0.00
OTHER THERAPEUTIC SERVI	5,443.24	86.90
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	213,511.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	322.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,658,046.50	67,385.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,085.57

TOTAL ANCILLARY	50,490,206.33	99,815.57
TOTAL ACCOMODATIONS	14,888,294.75	2,417,360.00
TOTAL CHARGES	65,378,501.08	2,517,175.57

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,004,577.65	ADJUSTMENTS	0.00
COVERED CHARGES	978,278.53	CONTRACTUAL ALLOW	113,777.63
NON-COVERED CHARGES	26,299.12	TOTAL MEDICAID LIAB	864,500.90
		LESS: COB	864,500.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 96

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	243	0	133,996.00	20,641.00
NURSERY CARE CHARGES	99	0	45,182.00	4,300.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	342	0	179,178.00	24,941.00
SPECIAL CARE SERVICES				
C C U	22	0	30,620.00	0.00
I C U	1	0	1,470.00	0.00
N I C U	1	0	1,114.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	33,204.00	0.00
TOTAL ACCOMODATIONS	366	0	212,382.00	24,941.00

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209,249.94	0.00
MED/SURG SUPPLY	158,242.86	0.00
LABORATORY-GENERAL	69,395.34	0.00
RADIOLOGY-DIAGNOSTIC	11,360.63	0.00
CT SCAN	20,426.60	0.00
PHYSICAL THERAPY	1,246.00	0.00
EKG/ECG	7,538.04	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	20,879.22	0.00
LABOR/DELIVERY ROOM	156,595.85	0.00
RESPIRATORY SERVICES	33,784.05	0.00
ANESTHESIA	5,201.48	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,258.70	0.00
RECOVERY ROOM	2,603.61	0.00
LABORATORY PATHOLOGIC	2,357.02	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	518.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,958.78	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,313.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,572.12	0.00
AUDIOLOGY	1,653.00	0.00
CARDIOLOGY	13,285.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,087.38	0.00
OTHER LAB SERVICES	1,417.68	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	772.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,468.88	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	67.32

TOTAL ANCILLARY	765,896.53	1,358.12
TOTAL ACCOMODATIONS	212,382.00	24,941.00
TOTAL CHARGES	978,278.53	26,299.12

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	38,148,730.05	ADJUSTMENTS	565,422.88
COVERED CHARGES	36,526,868.36	CONTRACTUAL ALLOW	25,373,999.20
NON-COVERED CHARGES	1,621,861.69	TOTAL MEDICAID LIAB	11,152,869.16
		LESS: COB	9,590.14
		LESS: COPAYMENT	20,664.00
		REIMBURSEMENT	11,122,615.02
		ALL OTHER	10,227,453.19
		FEE SCHEDULE-LAB	826,576.86
		INJECTABLE DRUGS	68,584.97

TOTAL NUMBER OF CLAIMS 36,191

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,660,495.13	79,224.62
MED/SURG SUPPLY	2,856,077.79	13,645.66
LABORATORY-GENERAL	14,339.40	90,122.89
RADIOLOGY-DIAGNOSTIC	2,690,579.43	24,306.84
CT SCAN	3,602,899.31	34,654.25
PHYSICAL THERAPY	532,409.00	9,168.80
EKG/ECG	297,226.95	13,941.60
IV THERAPY	125,842.80	437.60
OPERATING ROOM	3,171,918.83	62,883.18
LABOR/DELIVERY ROOM	122,110.58	0.00
RESPIRATORY SERVICES	366,069.96	31,051.90
ANESTHESIA	889,073.96	185,190.20
GI SERVICES	7,326.18	0.00
EMERGENCY ROOM	6,057,182.74	73,146.42
RECOVERY ROOM	1,091,012.33	4,198.38
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	543,069.55	14,398.67
OCCUPATIONAL THERAPY	167,942.00	1,989.00
SPEECH PATHOLOGY	173,016.00	889.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,074.10	0.00
PSYCHIATRIC SERVICES	277,829.60	12,000.00
LITHOTRIPSY	66,950.40	0.00
OTHER IMAGING SERVICES	1,107,525.28	27,497.63
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	46,158.71	70,190.44
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	304,310.38	744.48
AUDIOLOGY	8,517.69	0.00
CARDIOLOGY	877,508.82	15,647.66
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	371,268.28	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,733,459.30	2,862.19
OTHER LAB SERVICES	133,601.48	1,523.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,155.80	2,103.20
OTHER THERAPEUTIC SERVI	152,714.18	18,352.70
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,309,802.41	800,026.64
MRI SERVICES	547,218.30	15,628.65

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	270.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	912.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	21.76
INJECTABLE DRUGS	207,269.69	13,816.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,926.76

TOTAL ANCILLARY	36,526,868.36	1,621,861.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,526,868.36	1,621,861.69

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	82,033.67	ADJUSTMENTS	0.00
COVERED CHARGES	78,219.81	CONTRACTUAL ALLOW	41,864.62
NON-COVERED CHARGES	3,813.86	TOTAL MEDICAID LIAB	36,355.19
		LESS: COB	36,298.19
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,687.23-
		FEE SCHEDULE-LAB	2,659.93
		INJECTABLE DRUGS	27.30

TOTAL NUMBER OF CLAIMS 98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,840.77	0.00
MED/SURG SUPPLY	7,065.27	0.00
LABORATORY-GENERAL	0.00	462.86
RADIOLOGY-DIAGNOSTIC	2,536.02	232.32
CT SCAN	5,740.60	0.00
PHYSICAL THERAPY	3,627.00	0.00
EKG/ECG	188.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,174.29	0.00
LABOR/DELIVERY ROOM	2,854.94	0.00
RESPIRATORY SERVICES	33.00	5.50
ANESTHESIA	4,247.39	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,036.78	615.86
RECOVERY ROOM	3,544.12	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,511.40	453.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,029.60	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,452.86	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,756.69	0.00
OTHER LAB SERVICES	543.84	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	458.50	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,192.69	1,783.72
MRI SERVICES	3,297.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	260.40
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	87.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	78,219.81	3,813.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,219.81	3,813.86

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,379,227.35	ADJUSTMENTS	3,778.00
COVERED CHARGES	1,355,625.17	CONTRACTUAL ALLOW	1,220,825.17
NON-COVERED CHARGES	23,602.18	TOTAL MEDICAID LIAB	134,800.00
		LESS: COB	0.01
		LESS: COPAYMENT	1,974.00
		REIMBURSEMENT	132,825.99

TOTAL NUMBER OF CLAIMS 2,696

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,268.26	0.00
MED/SURG SUPPLY	58,750.93	0.00
LABORATORY-GENERAL	176,291.81	19,578.03
RADIOLOGY-DIAGNOSTIC	136,252.63	0.00
CT SCAN	67,560.98	0.00
PHYSICAL THERAPY	2,569.00	0.00
EKG/ECG	7,525.92	0.00
IV THERAPY	950.00	0.00
OPERATING ROOM	10,395.53	0.00
LABOR/DELIVERY ROOM	3,168.00	176.00
RESPIRATORY SERVICES	10,829.06	0.00
ANESTHESIA	3,515.75	212.30
GI SERVICES	0.00	0.00
EMERGENCY ROOM	708,136.31	2,251.50
RECOVERY ROOM	3,617.57	0.00
LABORATORY PATHOLOGIC	327.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	35,261.02	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,573.26	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,234.20	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,224.27	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,100.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,141.08	0.00
OTHER LAB SERVICES	1,631.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	2,296.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,804.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,200.11	950.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	434.28

TOTAL ANCILLARY	1,355,625.17	23,602.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,355,625.17	23,602.18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,506.59	ADJUSTMENTS	0.00
COVERED CHARGES	6,236.94	CONTRACTUAL ALLOW	5,617.15
NON-COVERED CHARGES	269.65	TOTAL MEDICAID LIAB	619.79
		LESS: COB	610.79
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	130.00	0.00
LABORATORY-GENERAL	767.69	269.65
RADIOLOGY-DIAGNOSTIC	948.00	0.00
CT SCAN	1,216.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	188.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,934.96	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	543.84	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	466.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,236.94	269.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,236.94	269.65

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,945,307.61	ADJUSTMENTS	55,474.87
COVERED CHARGES	3,806,443.17	CONTRACTUAL ALLOW	2,966,576.84
NON-COVERED CHARGES	138,864.44	TOTAL MEDICAID LIAB	839,866.33
		LESS: COB	0.00
		LESS: COPAYMENT	798.00
		REIMBURSEMENT	839,068.33

TOTAL NUMBER OF CLAIMS 215

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822,808.06	18,937.58
MED/SURG SUPPLY	723,645.44	0.00
LABORATORY-GENERAL	714.00	1,289.94
RADIOLOGY-DIAGNOSTIC	90,187.81	8,730.03
CT SCAN	152,452.19	4,419.20
PHYSICAL THERAPY	1,687.00	0.00
EKG/ECG	12,811.20	1,318.80
IV THERAPY	13,408.61	600.00
OPERATING ROOM	652,380.01	3,329.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,000.08	811.14
ANESTHESIA	135,575.09	48,450.05
GI SERVICES	0.00	0.00
EMERGENCY ROOM	48,072.86	260.50
RECOVERY ROOM	141,996.65	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	648,974.10	12,976.63
OCCUPATIONAL THERAPY	307.00	153.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,142.60	316.00
PSYCHIATRIC SERVICES	7,252.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,859.06	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,913.01	8,572.01
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,552.92	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	84,427.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	88,069.43	815.50
OTHER LAB SERVICES	1,708.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	26,850.60	4,852.90
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	83,554.67	22,920.51
MRI SERVICES	20,224.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	33.60
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,868.70	78.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,806,443.17	138,864.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,806,443.17	138,864.44

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	61,356,384.75	ADJUSTMENTS	1,559,091.84
COVERED CHARGES	59,181,853.90	CONTRACTUAL ALLOW	37,781,071.08
NON-COVERED CHARGES	2,174,530.85	TOTAL MEDICAID LIAB	21,400,782.82
		LESS: COB	40,337.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,360,445.40

TOTAL NUMBER OF ADMISSIONS 6,462

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	14,474	1	8,467,397.01	1,715,560.50
NURSERY CARE CHARGES	6,792	0	2,979,512.00	248,300.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	39	0.00	0.00
TOTAL ROUTINE	21,266	40	11,446,909.01	1,963,860.50
SPECIAL CARE SERVICES				
C C U	173	0	247,000.00	0.00
I C U	546	0	802,620.00	0.00
N I C U	563	0	624,675.50	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	194	0.00	132,020.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,282	194	1,674,295.50	132,020.00
TOTAL ACCOMODATIONS	22,548	234	13,121,204.51	2,095,880.50

INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,250,804.67	0.00
MED/SURG SUPPLY	7,213,971.31	1,251.35
LABORATORY-GENERAL	5,359,516.55	0.00
RADIOLOGY-DIAGNOSTIC	745,163.22	0.00
CT SCAN	1,684,891.60	0.00
PHYSICAL THERAPY	198,844.76	0.00
EKG/ECG	215,229.99	0.00
IV THERAPY	39,900.00	0.00
OPERATING ROOM	2,224,084.70	0.00
LABOR/DELIVERY ROOM	6,242,890.01	0.00
RESPIRATORY SERVICES	3,230,909.26	0.00
ANESTHESIA	573,095.76	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	762,851.56	0.00
RECOVERY ROOM	490,701.22	0.00
LABORATORY PATHOLOGIC	125,297.63	0.00
RADIOLOGY THERAPEUTIC	55,955.90	0.00
OCCUPATIONAL THERAPY	75,249.28	0.00
SPEECH PATHOLOGY	72,449.19	0.00
RENAL DIALYSIS	288,963.41	47,895.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	6,341.82
PSYCHIATRIC SERVICES	19,000.00	8,080.80
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	446,137.24	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	265,732.16	5,016.33
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	183,574.13	0.00
AUDIOLOGY	174,646.66	0.00
CARDIOLOGY	1,200,247.49	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	37,197.02	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	947,046.93	498.75
OTHER LAB SERVICES	137,707.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	17,149.24	63.53
SPECIAL CHARGES	141.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	323,635.29	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	653.48
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,457,664.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,849.29

TOTAL ANCILLARY	46,060,649.39	78,650.35
TOTAL ACCOMODATIONS	13,121,204.51	2,095,880.50
TOTAL CHARGES	59,181,853.90	2,174,530.85

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,643,110.64	ADJUSTMENTS	0.00
COVERED CHARGES	1,602,488.33	CONTRACTUAL ALLOW	235,255.92
NON-COVERED CHARGES	40,622.31	TOTAL MEDICAID LIAB	1,367,232.41
		LESS: COB	1,367,232.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	369	0	201,561.00	22,496.00
NURSERY CARE CHARGES	119	0	60,252.00	6,800.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	488	0	261,813.00	29,296.00
SPECIAL CARE SERVICES				
C C U	1	0	1,470.00	0.00
I C U	11	0	16,170.00	0.00
N I C U	46	0	51,244.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	16	0.00	10,944.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	58	16	68,884.00	10,944.00
TOTAL ACCOMODATIONS	546	16	330,697.00	40,240.00

ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,362.95	0.00
MED/SURG SUPPLY	240,058.90	0.00
LABORATORY-GENERAL	128,889.32	0.00
RADIOLOGY-DIAGNOSTIC	17,995.20	0.00
CT SCAN	12,891.39	0.00
PHYSICAL THERAPY	6,237.57	0.00
EKG/ECG	1,695.60	0.00
IV THERAPY	240.00	0.00
OPERATING ROOM	36,619.63	0.00
LABOR/DELIVERY ROOM	278,568.38	0.00
RESPIRATORY SERVICES	155,851.83	0.00
ANESTHESIA	11,725.95	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,257.64	0.00
RECOVERY ROOM	3,072.57	0.00
LABORATORY PATHOLOGIC	974.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,684.33	0.00
SPEECH PATHOLOGY	3,932.28	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	65.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,711.64	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,782.16	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,019.50	0.00
CARDIOLOGY	14,470.13	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	675.18	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,864.28	99.75
OTHER LAB SERVICES	1,407.32	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	72.60	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,507.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	217.56
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36,222.31	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,271,791.33	382.31
TOTAL ACCOMODATIONS	330,697.00	40,240.00
TOTAL CHARGES	1,602,488.33	40,622.31

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	36,093,752.60	ADJUSTMENTS	330,101.38
COVERED CHARGES	34,250,800.36	CONTRACTUAL ALLOW	25,451,834.15
NON-COVERED CHARGES	1,842,952.24	TOTAL MEDICAID LIAB	8,798,966.21
		LESS: COB	5,077.74
		LESS: COPAYMENT	24,351.00
		REIMBURSEMENT	8,769,537.47
		ALL OTHER	7,985,040.54
		FEE SCHEDULE-LAB	725,349.66
		INJECTABLE DRUGS	59,147.27

TOTAL NUMBER OF CLAIMS 30,803

OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,506,009.90	7,431.42
MED/SURG SUPPLY	2,670,315.94	9,430.84
LABORATORY-GENERAL	565.29	94,672.86
RADIOLOGY-DIAGNOSTIC	2,319,573.08	15,001.90
CT SCAN	3,643,438.57	101,305.56
PHYSICAL THERAPY	486,022.71	8,996.99
EKG/ECG	261,957.34	12,776.54
IV THERAPY	149,111.04	2,940.00
OPERATING ROOM	2,731,415.48	448,628.14
LABOR/DELIVERY ROOM	116,610.21	633.60
RESPIRATORY SERVICES	355,196.78	30,542.71
ANESTHESIA	973,340.90	21,785.20
GI SERVICES	1,329.65	559.35
EMERGENCY ROOM	5,705,072.77	202,730.35
RECOVERY ROOM	1,117,758.14	4,588.68
LABORATORY PATHOLOGIC	0.00	2,536.06
RADIOLOGY THERAPEUTIC	564,679.18	16,346.94
OCCUPATIONAL THERAPY	153,063.05	1,513.50
SPEECH PATHOLOGY	189,046.44	1,024.65
RENAL DIALYSIS	0.00	852.79
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,304.17	6,384.57
PSYCHIATRIC SERVICES	165,483.55	1,000.00
LITHOTRIPSY	140,595.84	0.00
OTHER IMAGING SERVICES	986,190.32	16,813.96
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,781.99	21,801.93
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	349,409.72	1,400.00
AUDIOLOGY	9,687.02	0.00
CARDIOLOGY	870,699.55	31,635.87
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	335,258.04	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,467,313.81	15,146.49
OTHER LAB SERVICES	142,125.83	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,944.24	522.72
OTHER THERAPEUTIC SERVI	70,434.17	24,849.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,995,881.81	711,122.47
MRI SERVICES	536,824.78	24,227.76

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	379.26
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	938.16	138.98
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	214,420.89	1,024.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,206.45

TOTAL ANCILLARY	34,250,800.36	1,842,952.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,250,800.36	1,842,952.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	77,281.16	ADJUSTMENTS	0.00
COVERED CHARGES	68,806.66	CONTRACTUAL ALLOW	48,324.00
NON-COVERED CHARGES	8,474.50	TOTAL MEDICAID LIAB	20,482.66
		LESS: COB	20,380.66
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,730.68-
		FEE SCHEDULE-LAB	1,706.85
		INJECTABLE DRUGS	23.83

TOTAL NUMBER OF CLAIMS 77

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

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NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,144.19	0.00
MED/SURG SUPPLY	2,937.10	0.00
LABORATORY-GENERAL	0.00	111.79
RADIOLOGY-DIAGNOSTIC	5,990.68	0.00
CT SCAN	12,683.31	6,351.84
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,365.74	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,582.01	0.00
LABOR/DELIVERY ROOM	211.20	0.00
RESPIRATORY SERVICES	519.45	0.00
ANESTHESIA	556.85	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,478.44	379.20
RECOVERY ROOM	1,234.34	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	7,052.47	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,283.04	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,084.79	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,572.64	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	509.88	72.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,514.47	1,559.07
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	86.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	68,806.66	8,474.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,806.66	8,474.50

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,746,298.93	ADJUSTMENTS	3,284.00
COVERED CHARGES	1,691,116.01	CONTRACTUAL ALLOW	1,544,392.15
NON-COVERED CHARGES	55,182.92	TOTAL MEDICAID LIAB	146,723.86
		LESS: COB	0.00
		LESS: COPAYMENT	2,520.00
		REIMBURSEMENT	144,203.86

TOTAL NUMBER OF CLAIMS 2,935

OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,170.67	0.00
MED/SURG SUPPLY	66,962.60	277.20
LABORATORY-GENERAL	230,968.18	23,530.49
RADIOLOGY-DIAGNOSTIC	157,130.64	354.57
CT SCAN	106,309.14	0.00
PHYSICAL THERAPY	325.05	0.00
EKG/ECG	7,228.57	0.00
IV THERAPY	4,560.00	300.00
OPERATING ROOM	6,648.24	3,259.55
LABOR/DELIVERY ROOM	4,224.00	0.00
RESPIRATORY SERVICES	8,342.36	0.00
ANESTHESIA	2,709.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	884,552.65	26,022.50
RECOVERY ROOM	3,843.02	0.00
LABORATORY PATHOLOGIC	738.87	0.00
RADIOLOGY THERAPEUTIC	7,184.60	0.00
OCCUPATIONAL THERAPY	229.50	0.00
SPEECH PATHOLOGY	384.12	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	65.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	33,534.62	1,062.87
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,858.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,499.04	0.00
OTHER LAB SERVICES	5,300.04	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	1,115.40	72.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	15,519.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	238.14
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,778.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,691,116.01	55,182.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,691,116.01	55,182.92

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,141.89	ADJUSTMENTS	0.00
COVERED CHARGES	11,770.58	CONTRACTUAL ALLOW	11,386.07
NON-COVERED CHARGES	1,371.31	TOTAL MEDICAID LIAB	384.51
		LESS: COB	360.51
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,096.63	0.00
MED/SURG SUPPLY	962.35	0.00
LABORATORY-GENERAL	1,603.94	523.54
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,747.90	145.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	294.03	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	858.66	557.37
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	189.60	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	145.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17.47	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,770.58	1,371.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,770.58	1,371.31

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,303,463.47	ADJUSTMENTS	68,165.20
COVERED CHARGES	4,218,908.82	CONTRACTUAL ALLOW	3,452,534.78
NON-COVERED CHARGES	84,554.65	TOTAL MEDICAID LIAB	766,374.04
		LESS: COB	0.00
		LESS: COPAYMENT	3,117.00
		REIMBURSEMENT	763,257.04

TOTAL NUMBER OF CLAIMS 224

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.
GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP61

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	824,979.31	252.30
MED/SURG SUPPLY	796,612.73	0.00
LABORATORY-GENERAL	235.62	264.13
RADIOLOGY-DIAGNOSTIC	53,526.63	5,785.50
CT SCAN	150,531.88	10,029.36
PHYSICAL THERAPY	955.44	0.00
EKG/ECG	13,564.80	1,318.80
IV THERAPY	24,840.00	1,020.00
OPERATING ROOM	637,636.47	0.00
LABOR/DELIVERY ROOM	2,863.79	0.00
RESPIRATORY SERVICES	3,059.88	371.57
ANESTHESIA	199,098.30	2,533.85
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,923.38	3,409.36
RECOVERY ROOM	159,727.11	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	931,997.57	15,502.17
OCCUPATIONAL THERAPY	263.34	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	821.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,588.47	195.00
PSYCHIATRIC SERVICES	23,620.80	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,350.99	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,166.14	429.33
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,592.38	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	102,264.92	3,176.68
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	86,007.81	3,057.33
OTHER LAB SERVICES	1,829.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	11,619.96	4,243.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,396.41	32,144.47
MRI SERVICES	7,336.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,318.89	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,218,908.82	84,554.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,218,908.82	84,554.65

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GA MED CTR
743 SPRING ST N.E.

GAINESVILLE GA 30501-3715

PROVIDER NUMBER 000000888A
NUMBER OF BEDS 461
TITLE XVIII NO: HOSP61

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,769,190.50	ADJUSTMENTS	431,901.05
COVERED CHARGES	9,156,365.77	CONTRACTUAL ALLOW	4,353,068.15
NON-COVERED CHARGES	612,824.73	TOTAL MEDICAID LIAB	4,803,297.62
		LESS: COB	11,444.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,791,853.34

TOTAL NUMBER OF ADMISSIONS 1,447

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,450	0	772,130.00	440,620.00
NURSERY CARE CHARGES	1,259	0	384,100.00	125,300.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	21	0.00	0.00
TOTAL ROUTINE	3,709	21	1,156,230.00	565,920.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	902	7	706,200.00	4,550.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	902	7	706,200.00	4,550.00
TOTAL ACCOMODATIONS	4,611	28	1,862,430.00	570,470.00

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,682,841.53	0.00
MED/SURG SUPPLY	767,040.44	47.00
LABORATORY-GENERAL	1,307,582.61	437.40
RADIOLOGY-DIAGNOSTIC	146,926.54	0.00
CT SCAN	229,822.68	14,156.20
PHYSICAL THERAPY	21,004.04	0.00
EKG/ECG	28,658.40	0.00
IV THERAPY	81,829.20	0.00
OPERATING ROOM	429,766.64	0.00
LABOR/DELIVERY ROOM	575,092.80	0.00
RESPIRATORY SERVICES	262,046.65	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	52,478.20	0.00
EMERGENCY ROOM	166,242.20	0.00
RECOVERY ROOM	80,878.20	0.00
LABORATORY PATHOLOGIC	63,744.40	0.00
RADIOLOGY THERAPEUTIC	29,577.40	0.00
OCCUPATIONAL THERAPY	2,186.40	0.00
SPEECH PATHOLOGY	11,641.48	0.00
RENAL DIALYSIS	2,040.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	300.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	60,177.34	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	65,436.00	8,328.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	72,075.60	0.00
AUDIOLOGY	27,120.00	0.00
CARDIOLOGY	111,032.74	0.00
AMBULATORY SURGERY	3,315.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,604.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,836.00	110.40
OTHER LAB SERVICES	31,422.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	331.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	40,724.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	103.55
INJECTABLE DRUGS	923,792.16	9,542.81
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,997.57

TOTAL ANCILLARY	7,293,935.77	42,354.73
TOTAL ACCOMODATIONS	1,862,430.00	570,470.00
TOTAL CHARGES	9,156,365.77	612,824.73

ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A

NUMBER OF BEDS 155

TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,769,183.12	ADJUSTMENTS	119,186.23
COVERED CHARGES	7,206,689.42	CONTRACTUAL ALLOW	4,184,082.50
NON-COVERED CHARGES	562,493.70	TOTAL MEDICAID LIAB	3,022,606.92
		LESS: COB	9,658.44
		LESS: COPAYMENT	12,693.00
		REIMBURSEMENT	3,000,255.48
		ALL OTHER	2,598,738.15
		FEE SCHEDULE-LAB	331,806.49
		INJECTABLE DRUGS	69,710.84

TOTAL NUMBER OF CLAIMS 12,210

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413,181.22	15,832.37
MED/SURG SUPPLY	426,645.68	2,472.72
LABORATORY-GENERAL	1,375.20	32,680.78
RADIOLOGY-DIAGNOSTIC	452,106.39	10,276.92
CT SCAN	449,817.76	19,611.56
PHYSICAL THERAPY	108,815.36	1,632.36
EKG/ECG	33,247.20	278.40
IV THERAPY	129,243.60	188.40
OPERATING ROOM	373,986.13	31,398.76
LABOR/DELIVERY ROOM	5,342.40	0.00
RESPIRATORY SERVICES	111,094.60	2,112.00
ANESTHESIA	0.00	0.00
GI SERVICES	77,046.80	17,367.80
EMERGENCY ROOM	898,254.89	1,200.80
RECOVERY ROOM	82,097.60	0.00
LABORATORY PATHOLOGIC	0.00	504.00
RADIOLOGY THERAPEUTIC	149,057.80	4,102.40
OCCUPATIONAL THERAPY	25,470.80	1,281.60
SPEECH PATHOLOGY	106,484.74	6,118.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,700.00	0.00
PSYCHIATRIC SERVICES	33,642.00	0.00
LITHOTRIPSY	66,913.44	0.00
OTHER IMAGING SERVICES	209,342.96	31,625.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,857.20	22,899.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	122,856.80	2,695.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,987.45	2,425.74
AMBULATORY SURGERY	7,900.80	172.80
OSTEOPATHIC SERVICES	0.00	0.00
E E G	96,873.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	210,978.00	1,968.00
OTHER LAB SERVICES	29,745.48	278.36
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	110.00	110.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,666,674.00	271,934.75
MRI SERVICES	215,212.00	5,954.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	186.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	33,768.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	596,859.32	74,990.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	135.33

TOTAL ANCILLARY	7,206,689.42	562,433.70
TOTAL ACCOMODATIONS	0.00	60.00
TOTAL CHARGES	7,206,689.42	562,493.70

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,702.03	ADJUSTMENTS	0.00
COVERED CHARGES	16,621.83	CONTRACTUAL ALLOW	6,965.22
NON-COVERED CHARGES	3,080.20	TOTAL MEDICAID LIAB	9,656.61
		LESS: COB	9,632.61
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,769.64-
		FEE SCHEDULE-LAB	1,769.64
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,969.18	0.00
MED/SURG SUPPLY	835.55	0.00
LABORATORY-GENERAL	0.00	428.40
RADIOLOGY-DIAGNOSTIC	1,109.34	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	632.18	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	56.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,329.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	423.68	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	432.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,834.30	2,579.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,621.83	3,080.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,621.83	3,080.20

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	270,195.19	ADJUSTMENTS	723.78
COVERED CHARGES	264,709.99	CONTRACTUAL ALLOW	214,094.99
NON-COVERED CHARGES	5,485.20	TOTAL MEDICAID LIAB	50,615.00
		LESS: COB	626.06
		LESS: COPAYMENT	984.00
		REIMBURSEMENT	49,004.94

TOTAL NUMBER OF CLAIMS 1,016

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,687.16	0.00
MED/SURG SUPPLY	10,378.45	602.36
LABORATORY-GENERAL	46,867.32	3,969.00
RADIOLOGY-DIAGNOSTIC	29,562.50	0.00
CT SCAN	10,486.56	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	765.60	0.00
IV THERAPY	9,043.20	0.00
OPERATING ROOM	1,576.85	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,236.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,480.86	0.00
RECOVERY ROOM	267.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,487.00	861.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,500.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	22.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,371.29	30.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	264,709.99	5,485.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	264,709.99	5,485.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,824.33	ADJUSTMENTS	0.00
COVERED CHARGES	7,179.42	CONTRACTUAL ALLOW	6,442.66
NON-COVERED CHARGES	644.91	TOTAL MEDICAID LIAB	736.76
		LESS: COB	736.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.53	4.31
MED/SURG SUPPLY	62.75	47.00
LABORATORY-GENERAL	1,298.50	201.60
RADIOLOGY-DIAGNOSTIC	452.64	0.00
CT SCAN	1,719.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	69.60	0.00
IV THERAPY	188.40	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	720.00	80.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	348.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,154.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	27.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,179.42	359.91
TOTAL ACCOMODATIONS	0.00	285.00
TOTAL CHARGES	7,179.42	644.91

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	360,214.18	ADJUSTMENTS	8,335.18
COVERED CHARGES	346,653.38	CONTRACTUAL ALLOW	221,580.68
NON-COVERED CHARGES	13,560.80	TOTAL MEDICAID LIAB	125,072.70
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	125,009.70

TOTAL NUMBER OF CLAIMS 30

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,779.96	2,622.52
MED/SURG SUPPLY	30,443.81	263.47
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	671.96	406.00
CT SCAN	5,300.00	0.00
PHYSICAL THERAPY	284.00	0.00
EKG/ECG	278.40	0.00
IV THERAPY	753.60	0.00
OPERATING ROOM	14,936.39	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,040.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,160.40	0.00
RECOVERY ROOM	2,102.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	117,678.20	2,848.20
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	562.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	795.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	57.60
OSTEOPATHIC SERVICES	0.00	0.00
E E G	397.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,908.00	0.00
OTHER LAB SERVICES	1,015.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	57.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,873.40	2,100.00
MRI SERVICES	2,154.00	1,560.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	127,370.26	3,645.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	346,653.38	13,560.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	346,653.38	13,560.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,924,545.19	ADJUSTMENTS	112,838.73
COVERED CHARGES	9,717,244.37	CONTRACTUAL ALLOW	5,150,742.93
NON-COVERED CHARGES	207,300.82	TOTAL MEDICAID LIAB	4,566,501.44
		LESS: COB	62,229.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,504,271.78

TOTAL NUMBER OF ADMISSIONS 1,354

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,240	0	1,049,286.00	109,339.00
NURSERY CARE CHARGES	1,154	0	483,810.00	2,037.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	25	0.00	0.00
TOTAL ROUTINE	3,394	25	1,533,096.00	111,376.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	874	22	738,004.00	15,026.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	874	22	738,004.00	15,026.00
TOTAL ACCOMODATIONS	4,268	47	2,271,100.00	126,402.00

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,591,532.51	0.00
MED/SURG SUPPLY	789,915.39	0.00
LABORATORY-GENERAL	1,362,949.30	1,150.77
RADIOLOGY-DIAGNOSTIC	119,357.45	0.00
CT SCAN	282,403.31	0.00
PHYSICAL THERAPY	26,857.54	0.00
EKG/ECG	29,263.32	0.00
IV THERAPY	59,809.52	0.00
OPERATING ROOM	493,791.43	0.00
LABOR/DELIVERY ROOM	540,259.20	0.00
RESPIRATORY SERVICES	285,545.89	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	44,582.40	0.00
EMERGENCY ROOM	181,043.90	0.00
RECOVERY ROOM	90,961.65	0.00
LABORATORY PATHOLOGIC	60,697.26	0.00
RADIOLOGY THERAPEUTIC	8,760.15	0.00
OCCUPATIONAL THERAPY	1,759.80	0.00
SPEECH PATHOLOGY	7,851.90	0.00
RENAL DIALYSIS	21,976.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	315.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,002.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	87,771.60	47,725.02
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	59,510.11	0.00
AUDIOLOGY	25,590.00	0.00
CARDIOLOGY	157,133.20	0.00
AMBULATORY SURGERY	2,756.25	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,397.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,193.40	0.00
OTHER LAB SERVICES	30,055.83	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	33,359.55	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	991,056.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	31,708.03

TOTAL ANCILLARY	7,446,144.37	80,898.82
TOTAL ACCOMODATIONS	2,271,100.00	126,402.00
TOTAL CHARGES	9,717,244.37	207,300.82

ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A

NUMBER OF BEDS 155

TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,792,712.40	ADJUSTMENTS	93,837.54
COVERED CHARGES	8,081,791.13	CONTRACTUAL ALLOW	5,120,562.70
NON-COVERED CHARGES	710,921.27	TOTAL MEDICAID LIAB	2,961,228.43
		LESS: COB	9,197.17
		LESS: COPAYMENT	8,655.00
		REIMBURSEMENT	2,943,376.26
		ALL OTHER	2,376,333.66
		FEE SCHEDULE-LAB	547,873.83
		INJECTABLE DRUGS	19,168.77

TOTAL NUMBER OF CLAIMS 12,258

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	420,348.09	26,395.82
MED/SURG SUPPLY	386,166.81	334.47
LABORATORY-GENERAL	10,363.50	41,734.49
RADIOLOGY-DIAGNOSTIC	475,776.61	5,185.91
CT SCAN	576,559.76	5,814.90
PHYSICAL THERAPY	96,699.68	124.74
EKG/ECG	46,386.72	73.08
IV THERAPY	219,864.72	0.00
OPERATING ROOM	452,498.40	5,520.58
LABOR/DELIVERY ROOM	687.60	0.00
RESPIRATORY SERVICES	76,390.29	766.71
ANESTHESIA	672.00	0.00
GI SERVICES	55,028.60	5,269.95
EMERGENCY ROOM	1,049,748.23	1,500.90
RECOVERY ROOM	86,169.05	0.00
LABORATORY PATHOLOGIC	0.00	1,339.38
RADIOLOGY THERAPEUTIC	252,350.21	1,356.60
OCCUPATIONAL THERAPY	35,810.36	710.79
SPEECH PATHOLOGY	110,126.06	91.35
RENAL DIALYSIS	0.00	1,072.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,467.50	0.00
PSYCHIATRIC SERVICES	36,136.80	0.00
LITHOTRIPSY	12,774.38	0.00
OTHER IMAGING SERVICES	196,093.51	26,051.55
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24,506.37	33,437.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	171,149.86	2,715.99
AUDIOLOGY	0.00	0.00
CARDIOLOGY	98,737.08	1,273.51
AMBULATORY SURGERY	15,416.98	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	106,930.05	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	257,638.25	2,963.40
OTHER LAB SERVICES	48,846.22	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	115.50	115.50
OTHER THERAPEUTIC SERVI	0.00	946.51
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,495,090.05	444,253.69
MRI SERVICES	193,992.05	4,658.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	19,329.90	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,919.94	92,353.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,859.83

TOTAL ANCILLARY	8,081,791.13	710,921.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,081,791.13	710,921.27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	15,998.49	ADJUSTMENTS	0.00
COVERED CHARGES	9,039.50	CONTRACTUAL ALLOW	6,800.11
NON-COVERED CHARGES	6,958.99	TOTAL MEDICAID LIAB	2,239.39
		LESS: COB	2,230.39
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	866.01-
		FEE SCHEDULE-LAB	857.63
		INJECTABLE DRUGS	8.38

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217.35	0.00
MED/SURG SUPPLY	69.62	0.00
LABORATORY-GENERAL	0.00	466.20
RADIOLOGY-DIAGNOSTIC	332.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	73.08	0.00
IV THERAPY	845.92	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	45.36	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,889.92	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	75.60
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	177.00	0.00
OTHER LAB SERVICES	141.12	141.12
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,222.56	793.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.77	5,482.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,039.50	6,958.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,039.50	6,958.99

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	249,768.19	ADJUSTMENTS	735.01
COVERED CHARGES	241,294.84	CONTRACTUAL ALLOW	198,698.69
NON-COVERED CHARGES	8,473.35	TOTAL MEDICAID LIAB	42,596.15
		LESS: COB	112.04
		LESS: COPAYMENT	648.00
		REIMBURSEMENT	41,836.11

TOTAL NUMBER OF CLAIMS 809

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,410.08	1.33
MED/SURG SUPPLY	4,250.74	0.00
LABORATORY-GENERAL	46,403.16	6,027.09
RADIOLOGY-DIAGNOSTIC	25,708.36	0.00
CT SCAN	8,168.53	0.00
PHYSICAL THERAPY	187.11	0.00
EKG/ECG	1,385.04	0.00
IV THERAPY	12,679.48	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,977.92	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	115,084.96	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	75.60	0.00
RADIOLOGY THERAPEUTIC	882.36	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	157.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,153.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	632.10	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,761.00	0.00
OTHER LAB SERVICES	1,302.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,790.89	1,614.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,284.06	724.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	105.21

TOTAL ANCILLARY	241,294.84	8,473.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	241,294.84	8,473.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,827.01	ADJUSTMENTS	0.00
COVERED CHARGES	1,066.02	CONTRACTUAL ALLOW	878.56
NON-COVERED CHARGES	760.99	TOTAL MEDICAID LIAB	187.46
		LESS: COB	187.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.04	22.80
MED/SURG SUPPLY	0.00	23.69
LABORATORY-GENERAL	506.64	11.34
RADIOLOGY-DIAGNOSTIC	143.96	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	69.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220.50	696.30
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	100.28	6.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,066.02	760.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,066.02	760.99

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	353,241.08	ADJUSTMENTS	3,565.74
COVERED CHARGES	333,175.87	CONTRACTUAL ALLOW	208,713.29
NON-COVERED CHARGES	20,065.21	TOTAL MEDICAID LIAB	124,462.58
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	124,393.58

TOTAL NUMBER OF CLAIMS 30

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,022.28	0.00
MED/SURG SUPPLY	51,415.38	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,547.38	517.65
CT SCAN	8,044.33	546.00
PHYSICAL THERAPY	317.52	0.00
EKG/ECG	1,012.68	0.00
IV THERAPY	2,719.36	0.00
OPERATING ROOM	16,061.99	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	796.95	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,971.50	0.00
RECOVERY ROOM	2,773.95	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	111,285.49	2,873.22
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	315.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	330.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,319.71	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,814.96	0.00
AMBULATORY SURGERY	609.60	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	416.85	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,731.20	0.00
OTHER LAB SERVICES	1,190.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	920.74
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,335.59	11,023.05
MRI SERVICES	3,160.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	982.20	4,184.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	333,175.87	20,065.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	333,175.87	20,065.21

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,774,661.56	ADJUSTMENTS	259,195.95
COVERED CHARGES	8,422,244.54	CONTRACTUAL ALLOW	4,486,124.27
NON-COVERED CHARGES	352,417.02	TOTAL MEDICAID LIAB	3,936,120.27
		LESS: COB	119,422.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,816,698.02

TOTAL NUMBER OF ADMISSIONS 1,140

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,790	0	934,076.00	161,267.42
NURSERY CARE CHARGES	955	0	463,854.00	4,771.60
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	13	0.00	0.00
TOTAL ROUTINE	2,745	13	1,397,930.00	166,039.02
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	752	90	742,457.77	71,712.14
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	752	90	742,457.77	71,712.14
TOTAL ACCOMODATIONS	3,497	103	2,140,387.77	237,751.16

INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,413,835.17	0.00
MED/SURG SUPPLY	613,712.98	0.00
LABORATORY-GENERAL	1,105,719.26	907.47
RADIOLOGY-DIAGNOSTIC	96,066.93	0.00
CT SCAN	274,346.82	0.00
PHYSICAL THERAPY	18,237.07	0.00
EKG/ECG	27,391.52	0.00
IV THERAPY	45,637.20	0.00
OPERATING ROOM	331,139.40	0.00
LABOR/DELIVERY ROOM	574,709.22	0.00
RESPIRATORY SERVICES	234,567.41	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	43,541.48	0.00
EMERGENCY ROOM	150,995.03	0.00
RECOVERY ROOM	62,673.70	0.00
LABORATORY PATHOLOGIC	49,134.92	0.00
RADIOLOGY THERAPEUTIC	32,529.23	0.00
OCCUPATIONAL THERAPY	4,844.15	0.00
SPEECH PATHOLOGY	2,547.60	0.00
RENAL DIALYSIS	31,624.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	46,182.43	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	74,529.00	84,942.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,112.73	0.00
AUDIOLOGY	24,683.40	0.00
CARDIOLOGY	130,719.41	0.00
AMBULATORY SURGERY	2,111.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,971.13	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,468.20	110.40
OTHER LAB SERVICES	24,688.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	25,063.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	771,074.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	28,705.09

TOTAL ANCILLARY	6,281,856.77	114,665.86
TOTAL ACCOMODATIONS	2,140,387.77	237,751.16
TOTAL CHARGES	8,422,244.54	352,417.02

ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,425.60	ADJUSTMENTS	0.00
COVERED CHARGES	4,393.60	CONTRACTUAL ALLOW	1,590.60
NON-COVERED CHARGES	32.00	TOTAL MEDICAID LIAB	2,803.00
		LESS: COB	2,803.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	1,008.00	32.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,008.00	32.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,008.00	32.00

ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	524.38	0.00
MED/SURG SUPPLY	597.00	0.00
LABORATORY-GENERAL	435.64	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,629.18	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	199.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,385.60	0.00
TOTAL ACCOMODATIONS	1,008.00	32.00
TOTAL CHARGES	4,393.60	32.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,732,101.13	ADJUSTMENTS	69,156.97
COVERED CHARGES	7,203,614.50	CONTRACTUAL ALLOW	5,006,363.71
NON-COVERED CHARGES	528,486.63	TOTAL MEDICAID LIAB	2,197,250.79
		LESS: COB	5,449.03
		LESS: COPAYMENT	9,282.00
		REIMBURSEMENT	2,182,519.76
		ALL OTHER	1,682,274.52
		FEE SCHEDULE-LAB	479,176.12
		INJECTABLE DRUGS	21,069.12

TOTAL NUMBER OF CLAIMS 9,405

OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	431,208.17	448.97
MED/SURG SUPPLY	360,545.69	2,304.41
LABORATORY-GENERAL	1,620.36	33,414.11
RADIOLOGY-DIAGNOSTIC	393,588.17	7,199.39
CT SCAN	490,139.49	43,705.74
PHYSICAL THERAPY	179,752.82	640.71
EKG/ECG	47,822.58	0.00
IV THERAPY	161,738.80	6,656.40
OPERATING ROOM	416,022.27	5,409.76
LABOR/DELIVERY ROOM	5,056.96	0.00
RESPIRATORY SERVICES	35,914.84	0.00
ANESTHESIA	448.00	0.00
GI SERVICES	56,620.70	1,047.90
EMERGENCY ROOM	851,788.04	9,509.14
RECOVERY ROOM	78,417.85	0.00
LABORATORY PATHOLOGIC	0.00	432.81
RADIOLOGY THERAPEUTIC	236,950.82	2,736.37
OCCUPATIONAL THERAPY	62,345.95	0.00
SPEECH PATHOLOGY	127,145.70	269.85
RENAL DIALYSIS	0.00	536.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,457.50	0.00
PSYCHIATRIC SERVICES	21,326.76	0.00
LITHOTRIPSY	24,967.80	0.00
OTHER IMAGING SERVICES	203,266.38	30,235.06
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,508.40	14,275.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	170,934.90	679.14
AUDIOLOGY	0.00	0.00
CARDIOLOGY	89,009.15	1,540.61
AMBULATORY SURGERY	14,686.71	172.80
OSTEOPATHIC SERVICES	0.00	0.00
E E G	103,355.31	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	214,700.32	3,120.20
OTHER LAB SERVICES	36,641.59	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	126.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,152,911.67	297,511.68
MRI SERVICES	127,174.62	4,546.92

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	28,709.10	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	61,837.08	59,940.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,026.06

TOTAL ANCILLARY	7,203,614.50	528,486.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,203,614.50	528,486.63

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,821.27	ADJUSTMENTS	0.00
COVERED CHARGES	14,670.49	CONTRACTUAL ALLOW	9,432.74
NON-COVERED CHARGES	6,150.78	TOTAL MEDICAID LIAB	5,237.75
		LESS: COB	5,234.75
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,069.04-
		FEE SCHEDULE-LAB	1,053.37
		INJECTABLE DRUGS	15.67

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	456.59	0.00
MED/SURG SUPPLY	133.02	0.00
LABORATORY-GENERAL	0.00	284.13
RADIOLOGY-DIAGNOSTIC	2,727.99	408.46
CT SCAN	1,031.94	3,245.73
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	753.60
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,622.60	110.40
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	939.11	647.85
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,714.10	694.89
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45.14	5.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,670.49	6,150.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,670.49	6,150.78

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	396,997.23	ADJUSTMENTS	744.19
COVERED CHARGES	381,445.38	CONTRACTUAL ALLOW	329,895.38
NON-COVERED CHARGES	15,551.85	TOTAL MEDICAID LIAB	51,550.00
		LESS: COB	65.17
		LESS: COPAYMENT	1,074.00
		REIMBURSEMENT	50,410.83

TOTAL NUMBER OF CLAIMS 961

OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,116.43	4.29
MED/SURG SUPPLY	3,577.82	0.00
LABORATORY-GENERAL	84,714.30	8,654.73
RADIOLOGY-DIAGNOSTIC	34,040.71	0.00
CT SCAN	26,141.02	4,601.46
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,046.32	0.00
IV THERAPY	14,674.00	444.80
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,592.01	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	151,288.01	710.40
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	1,412.01	0.00
RADIOLOGY THERAPEUTIC	11,708.20	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,710.94	361.61
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,836.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,273.51	0.00
AMBULATORY SURGERY	110.40	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,053.20	0.00
OTHER LAB SERVICES	2,000.53	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,766.73	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,382.74	774.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	381,445.38	15,551.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	381,445.38	15,551.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,598.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,495.68	CONTRACTUAL ALLOW	942.77
NON-COVERED CHARGES	102.32	TOTAL MEDICAID LIAB	552.91
		LESS: COB	549.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72.59	0.00
MED/SURG SUPPLY	24.00	0.00
LABORATORY-GENERAL	47.25	0.00
RADIOLOGY-DIAGNOSTIC	216.19	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	188.40	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	810.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25.75	96.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	110.90	5.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,495.68	102.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,495.68	102.32

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	489,099.47	ADJUSTMENTS	7,131.48
COVERED CHARGES	481,954.82	CONTRACTUAL ALLOW	361,209.66
NON-COVERED CHARGES	7,144.65	TOTAL MEDICAID LIAB	120,745.16
		LESS: COB	0.00
		LESS: COPAYMENT	840.00
		REIMBURSEMENT	119,905.16

TOTAL NUMBER OF CLAIMS 34

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET
MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC067301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,476.76	0.00
MED/SURG SUPPLY	33,571.10	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	148.08	213.15
CT SCAN	14,904.93	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	160.78	0.00
IV THERAPY	5,520.40	0.00
OPERATING ROOM	14,440.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	441.30	0.00
RECOVERY ROOM	1,944.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	259,492.28	3,951.52
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,123.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	999.60	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	772.80	57.60
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	952.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	121,856.76	2,562.84
MRI SERVICES	1,948.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	201.13	359.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	481,954.82	7,144.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	481,954.82	7,144.65

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONALMEDICAL CTR
821 NORTH COBB STREET

MILLEDGEVILLE GA 31061-2343

PROVIDER NUMBER 000000129A
NUMBER OF BEDS 155
TITLE XVIII NO: CC067301

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

CHARGES		PAYMENTS	
TOTAL CHARGES	660,175.34	ADJUSTMENTS	1,762.59
COVERED CHARGES	646,368.34	CONTRACTUAL ALLOW	174,833.35
NON-COVERED CHARGES	13,807.00	TOTAL MEDICAID LIAB	471,534.99
		LESS: COB	978.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	470,556.66

TOTAL NUMBER OF ADMISSIONS 88

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	303	0	104,535.00	4,790.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	303	0	104,535.00	4,790.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	303	0	104,535.00	4,790.00

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122,369.30	0.00
MED/SURG SUPPLY	86,391.50	0.00
LABORATORY-GENERAL	107,482.25	0.00
RADIOLOGY-DIAGNOSTIC	15,464.00	0.00
CT SCAN	56,306.00	0.00
PHYSICAL THERAPY	3,789.00	0.00
EKG/ECG	7,931.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	26,606.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,115.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,122.00	0.00
RECOVERY ROOM	5,052.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	89.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,678.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,774.00	8,050.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,045.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	690.24	0.00
OTHER LAB SERVICES	2,503.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,247.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	967.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,179.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	541,833.34	9,017.00
TOTAL ACCOMODATIONS	104,535.00	4,790.00
TOTAL CHARGES	646,368.34	13,807.00

ZERO PAID INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,747,938.96	ADJUSTMENTS	9,661.17
COVERED CHARGES	2,560,006.32	CONTRACTUAL ALLOW	1,397,899.70
NON-COVERED CHARGES	187,932.64	TOTAL MEDICAID LIAB	1,162,106.62
		LESS: COB	1,133.55
		LESS: COPAYMENT	6,123.00
		REIMBURSEMENT	1,154,850.07
		ALL OTHER	1,080,944.43
		FEE SCHEDULE-LAB	71,375.01
		INJECTABLE DRUGS	2,530.63

TOTAL NUMBER OF CLAIMS 5,390

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,381.95	2,255.20
MED/SURG SUPPLY	158,533.50	10,057.00
LABORATORY-GENERAL	267.00	20,680.00
RADIOLOGY-DIAGNOSTIC	251,235.67	3,776.00
CT SCAN	255,269.00	6,575.00
PHYSICAL THERAPY	42,031.00	6,278.00
EKG/ECG	31,642.00	206.00
IV THERAPY	218.00	0.00
OPERATING ROOM	122,440.00	17,663.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	35,127.00	580.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	511,081.00	7,185.00
RECOVERY ROOM	32,838.00	421.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	240.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	78,668.00	1,349.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,512.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,418.00	524.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	254,666.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,655.10	834.04
OTHER LAB SERVICES	28,698.00	755.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	100.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	466,183.70	99,420.00
MRI SERVICES	87,894.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,788.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	459.00
INJECTABLE DRUGS	20,519.40	5,011.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	159.00

TOTAL ANCILLARY	2,560,006.32	187,587.64
TOTAL ACCOMODATIONS	0.00	345.00
TOTAL CHARGES	2,560,006.32	187,932.64

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	47,104.15	ADJUSTMENTS	0.00
COVERED CHARGES	36,704.15	CONTRACTUAL ALLOW	1,741.86-
NON-COVERED CHARGES	10,400.00	TOTAL MEDICAID LIAB	38,446.01
		LESS: COB	38,380.01
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,249.42-
		FEE SCHEDULE-LAB	1,198.50
		INJECTABLE DRUGS	50.92

TOTAL NUMBER OF CLAIMS 71

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,564.15	29.00
MED/SURG SUPPLY	1,470.00	1,025.00
LABORATORY-GENERAL	0.00	193.00
RADIOLOGY-DIAGNOSTIC	5,475.00	304.00
CT SCAN	2,583.00	0.00
PHYSICAL THERAPY	206.00	0.00
EKG/ECG	412.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,420.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	561.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,421.00	70.00
RECOVERY ROOM	421.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	950.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,005.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,478.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	99.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,053.00	1,984.00
MRI SERVICES	1,382.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	6,763.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	204.00	32.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	36,704.15	10,400.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,704.15	10,400.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	170,713.27	ADJUSTMENTS	47.00
COVERED CHARGES	166,802.77	CONTRACTUAL ALLOW	130,634.38
NON-COVERED CHARGES	3,910.50	TOTAL MEDICAID LIAB	36,168.39
		LESS: COB	25.52
		LESS: COPAYMENT	993.00
		REIMBURSEMENT	35,149.87

TOTAL NUMBER OF CLAIMS 814

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,263.75	0.00
MED/SURG SUPPLY	5,610.00	121.00
LABORATORY-GENERAL	14,246.00	2,456.00
RADIOLOGY-DIAGNOSTIC	10,449.00	213.00
CT SCAN	5,040.00	0.00
PHYSICAL THERAPY	956.00	0.00
EKG/ECG	721.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	524.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,255.00	640.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	560.82	0.00
OTHER LAB SERVICES	309.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	10.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	73.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	107.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,794.70	363.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	166,802.77	3,910.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	166,802.77	3,910.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,290.25	ADJUSTMENTS	0.00
COVERED CHARGES	3,424.25	CONTRACTUAL ALLOW	308.79
NON-COVERED CHARGES	1,866.00	TOTAL MEDICAID LIAB	3,115.46
		LESS: COB	3,109.46
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371.25	0.00
MED/SURG SUPPLY	307.00	0.00
LABORATORY-GENERAL	638.00	9.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,024.00	100.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,751.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	69.00	6.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,424.25	1,866.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,424.25	1,866.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	47,352.56	ADJUSTMENTS	0.00
COVERED CHARGES	46,499.56	CONTRACTUAL ALLOW	26,765.26
NON-COVERED CHARGES	853.00	TOTAL MEDICAID LIAB	19,734.30
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	19,725.30

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,286.60	44.00
MED/SURG SUPPLY	14,633.50	213.00
LABORATORY-GENERAL	0.00	54.00
RADIOLOGY-DIAGNOSTIC	101.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	96.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,253.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,105.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	93.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	244.46	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	759.00	364.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.00	85.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,499.56	853.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,499.56	853.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A

NUMBER OF BEDS 36

TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2003 THROUGH 10/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

CHARGES		PAYMENTS	
TOTAL CHARGES	781,908.75	ADJUSTMENTS	66,902.85
COVERED CHARGES	767,989.75	CONTRACTUAL ALLOW	237,997.13
NON-COVERED CHARGES	13,919.00	TOTAL MEDICAID LIAB	529,992.62
		LESS: COB	117.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	529,875.50

TOTAL NUMBER OF ADMISSIONS 98

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	346	0	119,370.00	4,345.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	346	0	119,370.00	4,345.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	2	0	1,244.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	1,244.00	0.00
TOTAL ACCOMODATIONS	348	0	120,614.00	4,345.00

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,620.50	0.00
MED/SURG SUPPLY	75,998.50	0.00
LABORATORY-GENERAL	137,416.00	106.00
RADIOLOGY-DIAGNOSTIC	19,342.00	0.00
CT SCAN	54,458.00	0.00
PHYSICAL THERAPY	1,585.00	0.00
EKG/ECG	8,343.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,156.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30,911.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,616.00	0.00
RECOVERY ROOM	4,855.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,061.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,232.00	9,100.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,050.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	4,594.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	109.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,545.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	259.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	50,592.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	647,375.75	9,574.00
TOTAL ACCOMODATIONS	120,614.00	4,345.00
TOTAL CHARGES	767,989.75	13,919.00

ZERO PAID INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,932.50	ADJUSTMENTS	0.00
COVERED CHARGES	11,892.50	CONTRACTUAL ALLOW	405.38
NON-COVERED CHARGES	40.00	TOTAL MEDICAID LIAB	11,487.12
		LESS: COB	11,487.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5	0	1,725.00	40.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	1,725.00	40.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	1,725.00	40.00

ZERO PAID INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,113.25	0.00
MED/SURG SUPPLY	649.00	0.00
LABORATORY-GENERAL	2,887.00	0.00
RADIOLOGY-DIAGNOSTIC	216.00	0.00
CT SCAN	1,005.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	618.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	609.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	294.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,010.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	766.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,167.50	0.00
TOTAL ACCOMODATIONS	1,725.00	40.00
TOTAL CHARGES	11,892.50	40.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,078,414.89	ADJUSTMENTS	99,746.09
COVERED CHARGES	2,854,590.34	CONTRACTUAL ALLOW	1,556,488.86
NON-COVERED CHARGES	223,824.55	TOTAL MEDICAID LIAB	1,298,101.48
		LESS: COB	3,500.82
		LESS: COPAYMENT	3,804.00
		REIMBURSEMENT	1,290,796.66
		ALL OTHER	1,191,698.14
		FEE SCHEDULE-LAB	88,323.69
		INJECTABLE DRUGS	10,774.83

TOTAL NUMBER OF CLAIMS 5,812

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	185,670.99	2,777.25
MED/SURG SUPPLY	161,695.00	16,523.00
LABORATORY-GENERAL	1,068.00	12,752.00
RADIOLOGY-DIAGNOSTIC	282,149.00	7,381.00
CT SCAN	320,796.50	9,135.00
PHYSICAL THERAPY	37,754.00	2,069.00
EKG/ECG	43,611.00	206.00
IV THERAPY	0.00	0.00
OPERATING ROOM	119,302.00	19,110.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	41,035.00	35.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	568,952.00	1,219.00
RECOVERY ROOM	48,264.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	83,770.00	293.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	6,257.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	317.00	0.00
CARDIOLOGY	32,433.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	189,450.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,627.90	0.00
OTHER LAB SERVICES	31,389.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	593,180.45	126,903.55
MRI SERVICES	65,945.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	195.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,112.00	14,539.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	68.50	1,350.00

TOTAL ANCILLARY	2,854,590.34	220,895.55
TOTAL ACCOMODATIONS	0.00	2,929.00
TOTAL CHARGES	2,854,590.34	223,824.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	37,829.50	ADJUSTMENTS	0.00
COVERED CHARGES	35,615.00	CONTRACTUAL ALLOW	4,826.91
NON-COVERED CHARGES	2,214.50	TOTAL MEDICAID LIAB	30,788.09
		LESS: COB	30,764.09
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,738.80-
		FEE SCHEDULE-LAB	1,406.26
		INJECTABLE DRUGS	332.54

TOTAL NUMBER OF CLAIMS 59

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,606.50	21.00
MED/SURG SUPPLY	1,782.00	442.00
LABORATORY-GENERAL	0.00	201.00
RADIOLOGY-DIAGNOSTIC	2,388.00	0.00
CT SCAN	7,620.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	309.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	797.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	135.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,101.00	10.00
RECOVERY ROOM	421.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	395.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,478.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,962.00	1,473.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	34.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	620.50	33.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	35,615.00	2,214.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,615.00	2,214.50

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	188,096.44	ADJUSTMENTS	2,423.96
COVERED CHARGES	180,716.69	CONTRACTUAL ALLOW	145,967.98
NON-COVERED CHARGES	7,379.75	TOTAL MEDICAID LIAB	34,748.71
		LESS: COB	35.00
		LESS: COPAYMENT	1,059.00
		REIMBURSEMENT	33,654.71

TOTAL NUMBER OF CLAIMS 781

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,756.25	0.00
MED/SURG SUPPLY	5,787.00	54.00
LABORATORY-GENERAL	18,599.00	4,290.00
RADIOLOGY-DIAGNOSTIC	12,416.00	89.00
CT SCAN	2,583.00	0.00
PHYSICAL THERAPY	96.00	0.00
EKG/ECG	1,442.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	800.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,163.00	10.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	816.44	0.00
OTHER LAB SERVICES	309.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	20.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,839.00	613.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	107.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,110.00	2,196.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	180,716.69	7,379.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,716.69	7,379.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,834.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,655.75	CONTRACTUAL ALLOW	2,328.22
NON-COVERED CHARGES	179.00	TOTAL MEDICAID LIAB	1,327.53
		LESS: COB	1,318.53
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332.75	0.00
MED/SURG SUPPLY	230.00	0.00
LABORATORY-GENERAL	581.00	9.00
RADIOLOGY-DIAGNOSTIC	462.00	120.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,875.00	50.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	154.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,655.75	179.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,655.75	179.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A

NUMBER OF BEDS 36

TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2004 THROUGH 10/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

CHARGES		PAYMENTS	
TOTAL CHARGES	639,522.76	ADJUSTMENTS	14,287.62
COVERED CHARGES	629,540.76	CONTRACTUAL ALLOW	238,658.02
NON-COVERED CHARGES	9,982.00	TOTAL MEDICAID LIAB	390,882.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	390,882.74

TOTAL NUMBER OF ADMISSIONS 76

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	277	0	95,565.00	3,705.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	277	0	95,565.00	3,705.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	2	0	1,122.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	1,122.00	0.00
TOTAL ACCOMODATIONS	279	0	96,687.00	3,705.00

INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191,961.25	0.00
MED/SURG SUPPLY	52,089.25	0.00
LABORATORY-GENERAL	124,227.00	0.00
RADIOLOGY-DIAGNOSTIC	16,782.00	0.00
CT SCAN	38,441.00	0.00
PHYSICAL THERAPY	815.00	0.00
EKG/ECG	7,004.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,773.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	24,437.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,395.00	0.00
RECOVERY ROOM	4,152.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,619.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,286.00	5,600.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,030.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28.76	0.00
OTHER LAB SERVICES	2,398.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	410.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,826.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	267.00
INJECTABLE DRUGS	1,589.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	532,853.76	6,277.00
TOTAL ACCOMODATIONS	96,687.00	3,705.00
TOTAL CHARGES	629,540.76	9,982.00

ZERO PAID INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,566,726.61	ADJUSTMENTS	23,363.18
COVERED CHARGES	2,329,800.61	CONTRACTUAL ALLOW	1,327,818.35
NON-COVERED CHARGES	236,926.00	TOTAL MEDICAID LIAB	1,001,982.26
		LESS: COB	286.81
		LESS: COPAYMENT	3,864.00
		REIMBURSEMENT	997,831.45
		ALL OTHER	908,439.75
		FEE SCHEDULE-LAB	89,194.30
		INJECTABLE DRUGS	197.40

TOTAL NUMBER OF CLAIMS 4,653

OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,533.00	22,113.00
MED/SURG SUPPLY	122,661.00	3,105.00
LABORATORY-GENERAL	266.00	5,136.00
RADIOLOGY-DIAGNOSTIC	193,466.00	4,726.00
CT SCAN	191,806.00	19,997.00
PHYSICAL THERAPY	41,438.00	5,118.00
EKG/ECG	34,959.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	119,032.00	4,101.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,521.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	432,890.00	11,427.00
RECOVERY ROOM	33,707.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	148.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	67,739.00	1,240.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,242.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	31,002.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	218,210.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,788.36	0.00
OTHER LAB SERVICES	26,299.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	18,440.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	539,928.75	125,362.00
MRI SERVICES	42,010.00	10,790.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	554.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	178.00
INJECTABLE DRUGS	396.50	357.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	40.00

TOTAL ANCILLARY	2,329,800.61	236,926.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,329,800.61	236,926.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,582.75	ADJUSTMENTS	0.00
COVERED CHARGES	5,888.75	CONTRACTUAL ALLOW	1,158.62
NON-COVERED CHARGES	694.00	TOTAL MEDICAID LIAB	4,730.13
		LESS: COB	4,718.13
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	385.03-
		FEE SCHEDULE-LAB	291.35
		INJECTABLE DRUGS	93.68

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	421.00	0.00
MED/SURG SUPPLY	769.00	0.00
LABORATORY-GENERAL	0.00	19.00
RADIOLOGY-DIAGNOSTIC	909.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	326.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,054.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	415.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,800.00	675.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	194.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,888.75	694.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,888.75	694.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	197,613.68	ADJUSTMENTS	3,321.16
COVERED CHARGES	182,946.68	CONTRACTUAL ALLOW	141,900.71
NON-COVERED CHARGES	14,667.00	TOTAL MEDICAID LIAB	41,045.97
		LESS: COB	39.20
		LESS: COPAYMENT	1,404.00
		REIMBURSEMENT	39,602.77

TOTAL NUMBER OF CLAIMS 860

OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,387.75	2,645.00
MED/SURG SUPPLY	4,469.00	122.00
LABORATORY-GENERAL	16,898.00	2,164.00
RADIOLOGY-DIAGNOSTIC	8,374.00	455.00
CT SCAN	840.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	618.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	573.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,050.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	113,141.00	615.00
RECOVERY ROOM	421.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	158.18	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	8,107.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,718.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	258.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	298.25	301.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	182,946.68	14,667.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	182,946.68	14,667.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	21,713.22	ADJUSTMENTS	0.00
COVERED CHARGES	16,700.22	CONTRACTUAL ALLOW	16,459.46
NON-COVERED CHARGES	5,013.00	TOTAL MEDICAID LIAB	240.76
		LESS: COB	240.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 69

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,669.00	1,749.00
MED/SURG SUPPLY	303.00	13.00
LABORATORY-GENERAL	2,476.00	478.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	854.00	786.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,687.00	1,870.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	433.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	273.22	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	117.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,700.22	5,013.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,700.22	5,013.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.

FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,845.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,579.25	CONTRACTUAL ALLOW	3,200.74
NON-COVERED CHARGES	266.00	TOTAL MEDICAID LIAB	3,378.51
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,375.51

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006
TITLE XVIII NO: HOSP05

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	641.25	51.00
MED/SURG SUPPLY	2,715.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89.00	215.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,545.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	533.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	56.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,579.25	266.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,579.25	266.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CTR
601 N. BLUEBIRD BLVD.
FT VALLEY GA 31030-5082

PROVIDER NUMBER 000001449A
NUMBER OF BEDS 36
TITLE XVIII NO: HOSP05

PAYMENT DATES THROUGH
SERVICE DATES 11/01/2005 THROUGH 10/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	22,108,823.77	ADJUSTMENTS	305,553.08
COVERED CHARGES	21,953,602.77	CONTRACTUAL ALLOW	16,388,030.46
NON-COVERED CHARGES	155,221.00	TOTAL MEDICAID LIAB	5,565,572.31
		LESS: COB	51,212.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,514,360.08

TOTAL NUMBER OF ADMISSIONS 635

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,657	0	828,984.00	52,887.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	17	0.00	0.00
TOTAL ROUTINE	2,657	17	828,984.00	52,887.00
SPECIAL CARE SERVICES				
C C U	204	0	179,928.00	0.00
I C U	413	0	364,998.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	617	0	544,926.00	0.00
TOTAL ACCOMODATIONS	3,274	17	1,373,910.00	52,887.00

INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,687,274.66	0.00
MED/SURG SUPPLY	5,471,094.94	1,516.00
LABORATORY-GENERAL	2,656,654.75	78.00
RADIOLOGY-DIAGNOSTIC	669,743.05	0.00
CT SCAN	918,671.00	0.00
PHYSICAL THERAPY	92,013.00	0.00
EKG/ECG	181,248.00	0.00
IV THERAPY	82,826.00	0.00
OPERATING ROOM	2,494,333.22	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	587,557.00	0.00
ANESTHESIA	352,050.00	0.00
GI SERVICES	73,947.00	0.00
EMERGENCY ROOM	316,742.00	0.00
RECOVERY ROOM	349,120.00	0.00
LABORATORY PATHOLOGIC	77,504.00	0.00
RADIOLOGY THERAPEUTIC	2,269.00	0.00
OCCUPATIONAL THERAPY	50,790.00	0.00
SPEECH PATHOLOGY	20,109.00	0.00
RENAL DIALYSIS	31,158.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	306.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,659.00	8,456.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	136,406.00	81,146.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	175,927.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,522,359.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,188.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50,608.56	0.00
OTHER LAB SERVICES	98,044.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	489.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	115,198.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	31,668.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	8,276.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	222,530.59	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,067.00

TOTAL ANCILLARY	20,579,692.77	102,334.00
TOTAL ACCOMODATIONS	1,373,910.00	52,887.00
TOTAL CHARGES	21,953,602.77	155,221.00

ZERO PAID INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	71,558.82	ADJUSTMENTS	0.00
COVERED CHARGES	71,538.82	CONTRACTUAL ALLOW	44,315.25
NON-COVERED CHARGES	20.00	TOTAL MEDICAID LIAB	27,223.57
		LESS: COB	27,223.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	936.00	20.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	936.00	20.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	936.00	20.00

ZERO PAID INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,475.64	0.00
MED/SURG SUPPLY	51,384.00	0.00
LABORATORY-GENERAL	494.00	0.00
RADIOLOGY-DIAGNOSTIC	1,631.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	225.00	0.00
EKG/ECG	216.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,445.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,969.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,510.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	253.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,602.82	0.00
TOTAL ACCOMODATIONS	936.00	20.00
TOTAL CHARGES	71,538.82	20.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,979,997.47	ADJUSTMENTS	109,183.01
COVERED CHARGES	12,740,676.24	CONTRACTUAL ALLOW	10,514,038.02
NON-COVERED CHARGES	1,239,321.23	TOTAL MEDICAID LIAB	2,226,638.22
		LESS: COB	398.00
		LESS: COPAYMENT	4,761.00
		REIMBURSEMENT	2,221,479.22
		ALL OTHER	2,072,423.44
		FEE SCHEDULE-LAB	144,912.78
		INJECTABLE DRUGS	4,143.00

TOTAL NUMBER OF CLAIMS 5,532

OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	916,427.39	3,192.54
MED/SURG SUPPLY	1,559,243.87	3,552.00
LABORATORY-GENERAL	304.00	12,990.00
RADIOLOGY-DIAGNOSTIC	891,011.00	24,216.00
CT SCAN	1,942,122.00	89,538.00
PHYSICAL THERAPY	179,318.00	854.00
EKG/ECG	177,816.00	432.00
IV THERAPY	303,080.00	1,168.00
OPERATING ROOM	913,202.16	89,661.52
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	23,307.00	0.00
ANESTHESIA	327,966.00	6,513.00
GI SERVICES	53,395.00	0.00
EMERGENCY ROOM	1,252,313.00	2,581.00
RECOVERY ROOM	381,397.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,444.00	0.00
OCCUPATIONAL THERAPY	6,008.00	929.00
SPEECH PATHOLOGY	5,319.00	566.00
RENAL DIALYSIS	0.00	1,173.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,581.00	612.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	28,836.00	0.00
OTHER IMAGING SERVICES	128,323.00	454.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	29,603.00	1,274.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	268,663.00	16,845.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	701,356.50	33,033.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	60,613.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	107,451.42	4,268.00
OTHER LAB SERVICES	50,638.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	6,723.00	116.00
OTHER THERAPEUTIC SERVI	0.00	2,829.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,295,455.81	622,442.80
MRI SERVICES	92,939.00	5,630.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,820.09	311,885.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,566.00

TOTAL ANCILLARY	12,740,676.24	1,239,321.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,740,676.24	1,239,321.23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	104,997.94	ADJUSTMENTS	0.00
COVERED CHARGES	84,518.93	CONTRACTUAL ALLOW	46,155.59
NON-COVERED CHARGES	20,479.01	TOTAL MEDICAID LIAB	38,363.34
		LESS: COB	38,333.34
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	976.70-
		FEE SCHEDULE-LAB	968.58
		INJECTABLE DRUGS	8.12

TOTAL NUMBER OF CLAIMS 27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
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PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,403.53	0.00
MED/SURG SUPPLY	8,926.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,463.00	0.00
CT SCAN	13,523.00	3,893.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,760.00	0.00
IV THERAPY	292.00	584.00
OPERATING ROOM	3,278.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	39.00	0.00
ANESTHESIA	1,220.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,215.00	1,734.00
RECOVERY ROOM	996.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,080.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,614.00	481.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,616.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,045.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,584.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	403.00
OTHER LAB SERVICES	618.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	612.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,790.78	6,268.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	55.62	6,504.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	84,518.93	20,479.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	84,518.93	20,479.01

OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	947,062.80	ADJUSTMENTS	238.00
COVERED CHARGES	870,598.46	CONTRACTUAL ALLOW	803,048.46
NON-COVERED CHARGES	76,464.34	TOTAL MEDICAID LIAB	67,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	2,187.00
		REIMBURSEMENT	65,363.00

TOTAL NUMBER OF CLAIMS 1,351

OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,511.53	0.00
MED/SURG SUPPLY	43,219.00	0.00
LABORATORY-GENERAL	232,050.20	49,393.80
RADIOLOGY-DIAGNOSTIC	115,379.00	1,428.00
CT SCAN	59,881.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,744.00	0.00
IV THERAPY	22,966.00	292.00
OPERATING ROOM	3,849.00	3,686.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,343.00	0.00
ANESTHESIA	2,448.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	303,296.00	102.00
RECOVERY ROOM	2,944.00	0.00
LABORATORY PATHOLOGIC	2,302.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,474.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,054.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,069.00	516.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,168.00	0.00
OTHER LAB SERVICES	3,770.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,130.73	21,046.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	870,598.46	76,464.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	870,598.46	76,464.34

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,976.24	ADJUSTMENTS	0.00
COVERED CHARGES	3,842.24	CONTRACTUAL ALLOW	602.10-
NON-COVERED CHARGES	4,134.00	TOTAL MEDICAID LIAB	4,444.34
		LESS: COB	4,438.34
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
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PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.00	0.00
MED/SURG SUPPLY	218.00	0.00
LABORATORY-GENERAL	1,168.00	37.00
RADIOLOGY-DIAGNOSTIC	1,595.00	0.00
CT SCAN	0.00	3,893.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	741.00	204.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,842.24	4,134.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,842.24	4,134.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,397,097.63	ADJUSTMENTS	9,352.17
COVERED CHARGES	2,349,403.68	CONTRACTUAL ALLOW	2,119,628.59
NON-COVERED CHARGES	47,693.95	TOTAL MEDICAID LIAB	229,775.09
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	229,550.09

TOTAL NUMBER OF CLAIMS 59

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
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ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,363.45	915.75
MED/SURG SUPPLY	1,275,669.50	105.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,692.00	14,284.00
CT SCAN	22,015.00	0.00
PHYSICAL THERAPY	1,897.00	0.00
EKG/ECG	11,056.00	0.00
IV THERAPY	14,508.00	0.00
OPERATING ROOM	264,925.70	10,923.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,643.00	0.00
ANESTHESIA	41,877.00	0.00
GI SERVICES	4,617.00	0.00
EMERGENCY ROOM	5,330.00	0.00
RECOVERY ROOM	58,255.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,802.00	0.00
OCCUPATIONAL THERAPY	162.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	802.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	46,716.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,513.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,272.00	624.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	199,173.00	2,073.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	584.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,179.48	1,192.00
OTHER LAB SERVICES	1,459.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	115,186.53	13,055.80
MRI SERVICES	7,621.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,887.02	3,719.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,349,403.68	47,693.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,349,403.68	47,693.95

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	31,325.78	ADJUSTMENTS	0.00
COVERED CHARGES	28,194.28	CONTRACTUAL ALLOW	5,140.04
NON-COVERED CHARGES	3,131.50	TOTAL MEDICAID LIAB	23,054.24
		LESS: COB	23,045.24
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD.
P O BOX 107001
ROME GA 30165-1415

PROVIDER NUMBER 000001581A
NUMBER OF BEDS 201
TITLE XVIII NO: HOSP13

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,575.84	0.00
MED/SURG SUPPLY	15,323.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	216.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,101.50	1,700.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,755.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,022.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	338.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	510.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,024.34	583.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	176.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,194.28	3,131.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,194.28	3,131.50

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	88,584,509.08	ADJUSTMENTS	5,286,738.70
COVERED CHARGES	86,806,637.80	CONTRACTUAL ALLOW	49,064,473.99
NON-COVERED CHARGES	1,777,871.28	TOTAL MEDICAID LIAB	37,742,163.81
		LESS: COB	118,664.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	37,623,499.77

TOTAL NUMBER OF ADMISSIONS 6,648

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19,439	0	6,402,836.51	1,038,839.00
NURSERY CARE CHARGES	7,192	0	1,836,893.00	237,660.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	60	0.00	702.00
TOTAL ROUTINE	26,631	60	8,239,729.51	1,277,201.00
SPECIAL CARE SERVICES				
C C U	425	0	370,759.00	0.00
I C U	1,597	0	1,408,560.00	0.00
N I C U	4,125	0	3,201,834.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	512	0.00	208,864.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,147	512	4,981,153.00	208,864.00
TOTAL ACCOMODATIONS	32,778	572	13,220,882.51	1,486,065.00

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,319,073.70	0.00
MED/SURG SUPPLY	10,918,118.45	30,789.41
LABORATORY-GENERAL	10,484,958.50	15,187.94
RADIOLOGY-DIAGNOSTIC	2,053,518.10	0.00
CT SCAN	1,639,069.68	117,816.18
PHYSICAL THERAPY	617,284.73	0.00
EKG/ECG	140,521.71	0.00
IV THERAPY	239,659.40	0.00
OPERATING ROOM	4,970,629.31	0.00
LABOR/DELIVERY ROOM	1,619,492.13	0.00
RESPIRATORY SERVICES	3,961,445.58	0.00
ANESTHESIA	438,304.60	0.00
GI SERVICES	264,240.00	0.00
EMERGENCY ROOM	920,484.72	0.00
RECOVERY ROOM	1,556,173.65	0.00
LABORATORY PATHOLOGIC	381,558.01	0.00
RADIOLOGY THERAPEUTIC	632,713.67	0.00
OCCUPATIONAL THERAPY	262,107.35	0.00
SPEECH PATHOLOGY	119,984.19	0.00
RENAL DIALYSIS	268,659.91	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	9,201.54
PSYCHIATRIC SERVICES	6,143.85	0.00
LITHOTRIPSY	27,078.52	0.00
OTHER IMAGING SERVICES	682,857.43	24,239.42
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,843,020.64	23,829.53
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	248,568.19	0.00
AUDIOLOGY	214,555.92	228.54
CARDIOLOGY	2,313,165.73	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	161,576.04	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	431,679.90	0.00
OTHER LAB SERVICES	290,959.44	0.00
RECREATIONAL THERAPY	28,022.20	0.00
EDUCATION & TRAINING	3,810.19	9,277.22
OTHER THERAPEUTIC SERVI	0.00	10,619.63
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	500,657.15	16,588.10

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	24,452.18	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	6,503.53
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,210.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	27,525.24

TOTAL ANCILLARY	73,585,755.29	291,806.28
TOTAL ACCOMODATIONS	13,220,882.51	1,486,065.00
TOTAL CHARGES	86,806,637.80	1,777,871.28

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	64,507.02	ADJUSTMENTS	0.00
COVERED CHARGES	60,983.02	CONTRACTUAL ALLOW	19,682.50
NON-COVERED CHARGES	3,524.00	TOTAL MEDICAID LIAB	41,300.52
		LESS: COB	41,300.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	32	0	10,578.00	3,524.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	32	0	10,578.00	3,524.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	3	0	2,316.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	2,316.00	0.00
TOTAL ACCOMODATIONS	35	0	12,894.00	3,524.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,455.80	0.00
MED/SURG SUPPLY	11,796.23	0.00
LABORATORY-GENERAL	6,480.34	0.00
RADIOLOGY-DIAGNOSTIC	413.43	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,506.99	0.00
OPERATING ROOM	4,950.00	0.00
LABOR/DELIVERY ROOM	5,349.96	0.00
RESPIRATORY SERVICES	1,971.08	0.00
ANESTHESIA	661.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	476.96	0.00
RECOVERY ROOM	3,600.00	0.00
LABORATORY PATHOLOGIC	229.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,217.29	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	114.27	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	640.42	0.00
OTHER LAB SERVICES	225.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	48,089.02	0.00
TOTAL ACCOMODATIONS	12,894.00	3,524.00
TOTAL CHARGES	60,983.02	3,524.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	35,841,860.98	ADJUSTMENTS	541,066.10
COVERED CHARGES	33,702,590.77	CONTRACTUAL ALLOW	20,691,112.11
NON-COVERED CHARGES	2,139,270.21	TOTAL MEDICAID LIAB	13,011,478.66
		LESS: COB	24,893.22
		LESS: COPAYMENT	45,852.00
		REIMBURSEMENT	12,940,733.44
		ALL OTHER	12,326,902.99
		FEE SCHEDULE-LAB	613,830.45
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32,922

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,945,138.29	187,897.28
MED/SURG SUPPLY	2,424,380.06	52,883.51
LABORATORY-GENERAL	781.02	37,982.79
RADIOLOGY-DIAGNOSTIC	2,043,287.76	58,699.22
CT SCAN	2,308,287.61	107,709.93
PHYSICAL THERAPY	757,985.85	7,523.17
EKG/ECG	147,891.55	5,485.29
IV THERAPY	684,627.37	7,392.56
OPERATING ROOM	2,955,070.67	385,061.10
LABOR/DELIVERY ROOM	458,862.12	683.32
RESPIRATORY SERVICES	352,479.23	78,974.54
ANESTHESIA	297,687.75	4,290.00
GI SERVICES	427,281.98	59,298.00
EMERGENCY ROOM	2,876,395.35	24,238.97
RECOVERY ROOM	870,877.74	9,710.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,218,756.78	87,047.79
OCCUPATIONAL THERAPY	457,953.77	5,782.04
SPEECH PATHOLOGY	389,980.06	11,417.73
RENAL DIALYSIS	0.00	517.09
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	788,423.03	13,451.99
PSYCHIATRIC SERVICES	243,096.25	1,310.22
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,354,833.33	122,650.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	39,676.99	199,904.32
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	435,557.03	57,388.44
AUDIOLOGY	30,757.90	259.37
CARDIOLOGY	958,539.83	41,613.29
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	628,451.05	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,069,475.58	15,560.80
OTHER LAB SERVICES	267,158.09	4,447.87
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,242.09	302.02
OTHER THERAPEUTIC SERVI	0.00	65,073.13
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,127,976.64	432,799.30
MRI SERVICES	1,129,608.56	30,589.73

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,224.36	136.04
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	700.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,145.08	7,395.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10,991.91

TOTAL ANCILLARY	33,702,590.77	2,136,468.21
TOTAL ACCOMODATIONS	0.00	2,802.00
TOTAL CHARGES	33,702,590.77	2,139,270.21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	85,277.48	ADJUSTMENTS	0.00
COVERED CHARGES	65,098.80	CONTRACTUAL ALLOW	44,313.51
NON-COVERED CHARGES	20,178.68	TOTAL MEDICAID LIAB	20,785.29
		LESS: COB	20,668.29
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,336.16-
		FEE SCHEDULE-LAB	1,336.16
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 82

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,523.90	78.00
MED/SURG SUPPLY	2,459.55	174.47
LABORATORY-GENERAL	0.00	164.30
RADIOLOGY-DIAGNOSTIC	4,095.50	398.06
CT SCAN	9,068.98	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	81.87	0.00
IV THERAPY	3,705.35	0.00
OPERATING ROOM	644.60	0.00
LABOR/DELIVERY ROOM	2,020.13	141.00
RESPIRATORY SERVICES	61.74	2.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,828.36	560.05
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	14,664.42
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	340.99	77.93
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,602.05	570.42
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	163.63	327.26
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,259.47	819.02
OTHER LAB SERVICES	1,355.35	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,294.66	2,201.75
MRI SERVICES	3,592.67	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	65,098.80	20,178.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,098.80	20,178.68

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

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NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	864,887.63	ADJUSTMENTS	1,029.00
COVERED CHARGES	841,089.42	CONTRACTUAL ALLOW	716,842.42
NON-COVERED CHARGES	23,798.21	TOTAL MEDICAID LIAB	124,247.00
		LESS: COB	217.57
		LESS: COPAYMENT	2,682.00
		REIMBURSEMENT	121,347.43

TOTAL NUMBER OF CLAIMS 2,485

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,466.24	9.00
MED/SURG SUPPLY	37,090.06	271.50
LABORATORY-GENERAL	79,048.06	12,244.22
RADIOLOGY-DIAGNOSTIC	67,153.93	1,458.27
CT SCAN	30,098.68	3,849.07
PHYSICAL THERAPY	139.26	2,306.27
EKG/ECG	3,774.21	0.00
IV THERAPY	17,707.77	307.24
OPERATING ROOM	6,825.07	0.00
LABOR/DELIVERY ROOM	854.15	0.00
RESPIRATORY SERVICES	4,686.94	0.00
ANESTHESIA	660.00	0.00
GI SERVICES	2,120.00	0.00
EMERGENCY ROOM	480,605.86	578.02
RECOVERY ROOM	1,790.00	0.00
LABORATORY PATHOLOGIC	3,328.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	277.93	0.00
PSYCHIATRIC SERVICES	1,924.60	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	21,805.98	997.38
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,777.24
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,382.02	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,086.25	0.00
OTHER LAB SERVICES	2,456.62	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,807.59	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	841,089.42	23,798.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	841,089.42	23,798.21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	10,466.60	ADJUSTMENTS	0.00
COVERED CHARGES	9,430.26	CONTRACTUAL ALLOW	8,246.40
NON-COVERED CHARGES	1,036.34	TOTAL MEDICAID LIAB	1,183.86
		LESS: COB	1,171.86
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218.10	0.00
MED/SURG SUPPLY	477.59	0.00
LABORATORY-GENERAL	837.85	221.46
RADIOLOGY-DIAGNOSTIC	818.16	0.00
CT SCAN	2,578.36	476.53
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	163.74	81.87
IV THERAPY	307.24	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	89.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,173.58	238.48
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	192.46	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	574.18	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	18.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,430.26	1,036.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,430.26	1,036.34

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE

ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,505,168.28	ADJUSTMENTS	56,616.41
COVERED CHARGES	6,410,378.69	CONTRACTUAL ALLOW	4,680,487.46
NON-COVERED CHARGES	94,789.59	TOTAL MEDICAID LIAB	1,729,891.23
		LESS: COB	0.00
		LESS: COPAYMENT	972.00
		REIMBURSEMENT	1,728,919.23

TOTAL NUMBER OF CLAIMS 398

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,332,341.52	8,901.43
MED/SURG SUPPLY	512,837.58	1,109.17
LABORATORY-GENERAL	0.00	359.16
RADIOLOGY-DIAGNOSTIC	47,599.79	3,568.62
CT SCAN	97,620.97	953.06
PHYSICAL THERAPY	6,464.82	233.15
EKG/ECG	3,602.28	245.61
IV THERAPY	132,967.76	614.48
OPERATING ROOM	533,865.13	24,005.82
LABOR/DELIVERY ROOM	170.83	0.00
RESPIRATORY SERVICES	34,790.74	0.00
ANESTHESIA	53,878.00	330.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,879.13	0.00
RECOVERY ROOM	81,517.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,256,721.14	8,568.16
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	22,619.79	1,206.51
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	81,235.56	0.00
OTHER IMAGING SERVICES	4,446.25	332.46
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	640.64	4,290.91
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,983.38	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,351.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	56,696.92	311.72
OTHER LAB SERVICES	1,939.53	0.00
RECREATIONAL THERAPY	0.00	233.79
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	24,378.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	79,420.95	15,147.14
MRI SERVICES	24,786.73	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,410,378.69	94,789.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,410,378.69	94,789.59

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	99,970,169.81	ADJUSTMENTS	4,730,429.29
COVERED CHARGES	97,240,363.46	CONTRACTUAL ALLOW	58,253,806.53
NON-COVERED CHARGES	2,729,806.35	TOTAL MEDICAID LIAB	38,986,556.93
		LESS: COB	104,537.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	38,882,019.38

TOTAL NUMBER OF ADMISSIONS 7,016

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21,173	0	7,514,766.00	1,763,658.00
NURSERY CARE CHARGES	7,619	0	2,118,329.00	372,990.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	84	0.00	0.00
TOTAL ROUTINE	28,792	84	9,633,095.00	2,136,648.00
SPECIAL CARE SERVICES				
C C U	522	0	523,697.00	0.00
I C U	1,586	0	1,637,983.00	0.00
N I C U	4,009	0	3,523,792.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	659	0.00	302,313.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,117	659	5,685,472.00	302,313.00
TOTAL ACCOMODATIONS	34,909	743	15,318,567.00	2,438,961.00

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
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NUMBER OF BEDS 403
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005
TITLE XVIII NO: 11S007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,087,557.79	0.00
MED/SURG SUPPLY	11,983,578.65	32,534.09
LABORATORY-GENERAL	12,160,735.26	16,714.00
RADIOLOGY-DIAGNOSTIC	1,999,235.53	0.00
CT SCAN	1,781,035.96	25,705.09
PHYSICAL THERAPY	639,245.54	0.00
EKG/ECG	163,360.11	0.00
IV THERAPY	769,830.81	0.00
OPERATING ROOM	5,790,461.81	0.00
LABOR/DELIVERY ROOM	1,981,911.71	0.00
RESPIRATORY SERVICES	3,842,107.73	0.00
ANESTHESIA	616,028.76	0.00
GI SERVICES	277,200.00	0.00
EMERGENCY ROOM	1,442,220.36	0.00
RECOVERY ROOM	2,251,405.75	0.00
LABORATORY PATHOLOGIC	455,291.00	0.00
RADIOLOGY THERAPEUTIC	674,855.74	0.00
OCCUPATIONAL THERAPY	271,100.38	0.00
SPEECH PATHOLOGY	134,990.77	0.00
RENAL DIALYSIS	256,962.09	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	15,633.93
PSYCHIATRIC SERVICES	13,019.39	0.00
LITHOTRIPSY	42,648.60	0.00
OTHER IMAGING SERVICES	587,569.67	85,500.00
BLOOD	346.50	0.00
BLOOD STORAGE & PRO.	2,013,665.01	29,009.68
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	215,066.09	0.00
AUDIOLOGY	229,540.68	0.00
CARDIOLOGY	2,206,243.36	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	132,481.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	985,632.09	0.00
OTHER LAB SERVICES	327,909.47	491.24
RECREATIONAL THERAPY	41,075.28	0.00
EDUCATION & TRAINING	22,926.35	0.00
OTHER THERAPEUTIC SERVI	0.00	18,237.54
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	510,948.69	6,998.22

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	12,309.27	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,299.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	60,021.56

TOTAL ANCILLARY	81,921,796.46	290,845.35
TOTAL ACCOMODATIONS	15,318,567.00	2,438,961.00
TOTAL CHARGES	97,240,363.46	2,729,806.35

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	29,532.79	ADJUSTMENTS	0.00
COVERED CHARGES	28,274.79	CONTRACTUAL ALLOW	3,644.33
NON-COVERED CHARGES	1,258.00	TOTAL MEDICAID LIAB	24,630.46
		LESS: COB	24,630.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	9	0	3,159.00	1,258.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9	0	3,159.00	1,258.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	9	0	3,159.00	1,258.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
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SERVICE DATES 08/01/2004 THROUGH 07/31/2005
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PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,561.50	0.00
MED/SURG SUPPLY	3,352.74	0.00
LABORATORY-GENERAL	3,403.00	0.00
RADIOLOGY-DIAGNOSTIC	569.21	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	176.15	0.00
EKG/ECG	0.00	0.00
IV THERAPY	307.24	0.00
OPERATING ROOM	4,158.00	0.00
LABOR/DELIVERY ROOM	2,497.91	0.00
RESPIRATORY SERVICES	916.46	0.00
ANESTHESIA	404.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,774.80	0.00
LABORATORY PATHOLOGIC	464.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	173.03	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	155.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	202.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,115.79	0.00
TOTAL ACCOMODATIONS	3,159.00	1,258.00
TOTAL CHARGES	28,274.79	1,258.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

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TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	37,385,110.80	ADJUSTMENTS	1,230,173.10
COVERED CHARGES	36,231,103.15	CONTRACTUAL ALLOW	23,200,119.01
NON-COVERED CHARGES	1,154,007.65	TOTAL MEDICAID LIAB	13,030,984.14
		LESS: COB	17,398.03
		LESS: COPAYMENT	41,751.00
		REIMBURSEMENT	12,971,835.11
		ALL OTHER	12,236,682.56
		FEE SCHEDULE-LAB	735,151.53
		INJECTABLE DRUGS	1.02

TOTAL NUMBER OF CLAIMS 32,743

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,828,633.70	51,946.30
MED/SURG SUPPLY	2,730,565.84	40,193.51
LABORATORY-GENERAL	11,839.00	74,332.23
RADIOLOGY-DIAGNOSTIC	1,896,240.62	16,520.57
CT SCAN	2,137,890.87	21,195.32
PHYSICAL THERAPY	740,127.41	2,367.60
EKG/ECG	141,533.93	9,636.42
IV THERAPY	795,868.84	307.24
OPERATING ROOM	3,185,909.35	100,255.29
LABOR/DELIVERY ROOM	418,593.43	187.91
RESPIRATORY SERVICES	407,030.41	34,308.10
ANESTHESIA	304,379.52	6,469.30
GI SERVICES	478,674.41	13,200.00
EMERGENCY ROOM	4,064,306.81	2,702.05
RECOVERY ROOM	978,555.20	14,755.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,290,546.36	9,840.98
OCCUPATIONAL THERAPY	446,431.45	4,872.75
SPEECH PATHOLOGY	597,702.16	2,972.54
RENAL DIALYSIS	0.00	2,056.26
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	800,557.15	4,285.36
PSYCHIATRIC SERVICES	252,182.33	1,885.02
LITHOTRIPSY	14,216.20	0.00
OTHER IMAGING SERVICES	1,351,812.48	107,965.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	57,359.66	92,292.27
ONCOLOGY	2,160.00	0.00
NUCLEAR MEDICINE	385,032.45	39,681.56
AUDIOLOGY	7,265.95	0.00
CARDIOLOGY	915,717.01	7,026.66
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	542,420.23	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,603,403.99	4,777.40
OTHER LAB SERVICES	269,972.55	3,316.28
RECREATIONAL THERAPY	188.07	0.00
EDUCATION & TRAINING	16,155.61	579.38
OTHER THERAPEUTIC SERVI	740.36	1,143.59
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,626,989.19	470,728.04
MRI SERVICES	923,043.53	4,584.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	7,053.28	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.80	486.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,137.41

TOTAL ANCILLARY	36,231,103.15	1,154,007.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,231,103.15	1,154,007.65

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

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NUMBER OF BEDS 403
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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	130,738.58	ADJUSTMENTS	0.00
COVERED CHARGES	118,539.59	CONTRACTUAL ALLOW	43,271.58
NON-COVERED CHARGES	12,198.99	TOTAL MEDICAID LIAB	75,268.01
		LESS: COB	75,145.01
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,246.60-
		FEE SCHEDULE-LAB	2,246.60
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 110

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,831.55	0.00
MED/SURG SUPPLY	7,946.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,261.37	0.00
CT SCAN	6,894.63	0.00
PHYSICAL THERAPY	1,421.63	0.00
EKG/ECG	180.12	0.00
IV THERAPY	5,813.66	0.00
OPERATING ROOM	11,440.76	2,079.00
LABOR/DELIVERY ROOM	3,758.20	0.00
RESPIRATORY SERVICES	140.38	1,153.20
ANESTHESIA	1,328.25	0.00
GI SERVICES	2,400.00	0.00
EMERGENCY ROOM	9,510.84	85.00
RECOVERY ROOM	3,230.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,708.17	0.00
SPEECH PATHOLOGY	1,832.65	732.65
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	676.49	77.93
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,343.74	4,865.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	612.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,459.90	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	660.31	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,565.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,402.90	0.00
OTHER LAB SERVICES	924.92	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	375.36	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,264.00	2,593.50
MRI SERVICES	3,168.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	118,539.59	12,198.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,539.59	12,198.99

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	980,393.14	ADJUSTMENTS	1,911.00
COVERED CHARGES	962,998.29	CONTRACTUAL ALLOW	865,301.29
NON-COVERED CHARGES	17,394.85	TOTAL MEDICAID LIAB	97,697.00
		LESS: COB	31.72
		LESS: COPAYMENT	1,524.00
		REIMBURSEMENT	96,141.28

TOTAL NUMBER OF CLAIMS 1,954

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,507.13	18.00
MED/SURG SUPPLY	43,031.99	39.37
LABORATORY-GENERAL	93,369.60	7,287.72
RADIOLOGY-DIAGNOSTIC	47,429.15	0.00
CT SCAN	28,035.22	2,672.10
PHYSICAL THERAPY	456.19	0.00
EKG/ECG	2,611.74	0.00
IV THERAPY	25,869.19	307.24
OPERATING ROOM	11,078.51	0.00
LABOR/DELIVERY ROOM	1,127.46	0.00
RESPIRATORY SERVICES	1,703.76	0.00
ANESTHESIA	1,155.00	0.00
GI SERVICES	1,200.00	0.00
EMERGENCY ROOM	572,194.51	531.00
RECOVERY ROOM	3,965.00	0.00
LABORATORY PATHOLOGIC	1,577.00	0.00
RADIOLOGY THERAPEUTIC	10,372.17	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,398.72	0.00
PSYCHIATRIC SERVICES	3,362.87	423.42
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,163.74	4,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	155.00	310.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,925.69	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	37,220.20	0.00
OTHER LAB SERVICES	722.47	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	254.98	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	111.00	31.00

TOTAL ANCILLARY	962,998.29	16,119.85
TOTAL ACCOMODATIONS	0.00	1,275.00
TOTAL CHARGES	962,998.29	17,394.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,088.41	ADJUSTMENTS	0.00
COVERED CHARGES	4,981.41	CONTRACTUAL ALLOW	2,526.14
NON-COVERED CHARGES	107.00	TOTAL MEDICAID LIAB	2,455.27
		LESS: COB	2,452.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261.20	0.00
MED/SURG SUPPLY	468.96	0.00
LABORATORY-GENERAL	632.00	22.00
RADIOLOGY-DIAGNOSTIC	271.16	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	307.24	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,038.65	85.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,981.41	107.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,981.41	107.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

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TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,395,128.22	ADJUSTMENTS	143,180.74
COVERED CHARGES	4,340,981.84	CONTRACTUAL ALLOW	3,096,711.23
NON-COVERED CHARGES	54,146.38	TOTAL MEDICAID LIAB	1,244,270.61
		LESS: COB	0.00
		LESS: COPAYMENT	831.00
		REIMBURSEMENT	1,243,439.61

TOTAL NUMBER OF CLAIMS 286

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,652,865.62	12,222.77
MED/SURG SUPPLY	586,094.87	1,578.10
LABORATORY-GENERAL	3,060.00	721.00
RADIOLOGY-DIAGNOSTIC	53,690.62	3,159.14
CT SCAN	34,483.94	0.00
PHYSICAL THERAPY	4,951.71	0.00
EKG/ECG	5,223.48	360.24
IV THERAPY	73,468.07	0.00
OPERATING ROOM	527,614.85	1,115.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	120,817.81	7,207.50
ANESTHESIA	51,687.55	231.00
GI SERVICES	1,200.00	0.00
EMERGENCY ROOM	19,450.36	0.00
RECOVERY ROOM	87,915.90	735.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	690,428.26	7,788.74
OCCUPATIONAL THERAPY	560.29	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	49,401.50	554.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	184,810.60	0.00
OTHER IMAGING SERVICES	5,841.91	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,210.68	6,734.39
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,924.49	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,714.92	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	58,733.52	0.00
OTHER LAB SERVICES	1,077.61	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	69,694.17	11,253.50
MRI SERVICES	11,923.47	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	135.64	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	486.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,340,981.84	54,146.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,340,981.84	54,146.38

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	86,610.48	ADJUSTMENTS	0.00
COVERED CHARGES	86,511.48	CONTRACTUAL ALLOW	24,018.11
NON-COVERED CHARGES	99.00	TOTAL MEDICAID LIAB	62,493.37
		LESS: COB	62,436.37
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,715.22	0.00
MED/SURG SUPPLY	48,800.71	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	453.86	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	90.06	0.00
IV THERAPY	307.24	0.00
OPERATING ROOM	8,316.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2.20	0.00
ANESTHESIA	866.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,673.11	0.00
RECOVERY ROOM	1,680.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	20,516.88	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	670.95	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	419.00	99.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,511.48	99.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,511.48	99.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	107,256,659.33	ADJUSTMENTS	6,349,310.83
COVERED CHARGES	105,684,859.63	CONTRACTUAL ALLOW	64,378,635.75
NON-COVERED CHARGES	1,571,799.70	TOTAL MEDICAID LIAB	41,306,223.88
		LESS: COB	253,147.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	41,053,076.51

TOTAL NUMBER OF ADMISSIONS 7,359

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	20,984	0	8,327,098.00	841,841.00
NURSERY CARE CHARGES	8,391	0	2,584,603.00	215,310.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	138	0.00	768.00
TOTAL ROUTINE	29,375	138	10,911,701.00	1,057,919.00
SPECIAL CARE SERVICES				
C C U	636	0	647,276.00	0.00
I C U	1,782	0	1,862,099.00	0.00
N I C U	4,201	0	3,859,296.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	694	0.00	311,828.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,619	694	6,368,671.00	311,828.00
TOTAL ACCOMODATIONS	35,994	832	17,280,372.00	1,369,747.00

INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006
TITLE XVIII NO: 11S007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,866,268.94	0.00
MED/SURG SUPPLY	12,962,382.96	48,853.45
LABORATORY-GENERAL	12,845,982.09	16,608.00
RADIOLOGY-DIAGNOSTIC	2,170,883.24	0.00
CT SCAN	1,604,499.72	0.00
PHYSICAL THERAPY	661,321.23	0.00
EKG/ECG	153,449.24	0.00
IV THERAPY	1,663,100.01	0.00
OPERATING ROOM	7,431,166.73	0.00
LABOR/DELIVERY ROOM	2,035,340.98	0.00
RESPIRATORY SERVICES	4,895,660.53	0.00
ANESTHESIA	631,455.13	0.00
GI SERVICES	309,450.90	0.00
EMERGENCY ROOM	1,415,299.68	0.00
RECOVERY ROOM	2,147,845.60	0.00
LABORATORY PATHOLOGIC	413,343.40	0.00
RADIOLOGY THERAPEUTIC	633,312.36	0.00
OCCUPATIONAL THERAPY	333,468.16	0.00
SPEECH PATHOLOGY	149,961.03	0.00
RENAL DIALYSIS	341,107.68	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	33,618.01
PSYCHIATRIC SERVICES	9,601.77	0.00
LITHOTRIPSY	28,432.40	0.00
OTHER IMAGING SERVICES	736,689.18	4,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,868,069.00	26,502.41
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	202,901.06	0.00
AUDIOLOGY	262,082.01	147.32
CARDIOLOGY	2,408,315.62	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	79,070.26	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,041,690.43	0.00
OTHER LAB SERVICES	508,759.44	0.00
RECREATIONAL THERAPY	77,694.70	0.00
EDUCATION & TRAINING	27,887.13	0.00
OTHER THERAPEUTIC SERVI	0.00	15,299.29
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	461,414.04	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	21,329.21	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,576.36
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,251.77	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	53,947.86

TOTAL ANCILLARY	88,404,487.63	202,052.70
TOTAL ACCOMODATIONS	17,280,372.00	1,369,747.00
TOTAL CHARGES	105,684,859.63	1,571,799.70

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	59,213.81	ADJUSTMENTS	0.00
COVERED CHARGES	53,992.81	CONTRACTUAL ALLOW	24,854.83
NON-COVERED CHARGES	5,221.00	TOTAL MEDICAID LIAB	29,137.98
		LESS: COB	29,137.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	30	0	12,024.00	5,221.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	30	0	12,024.00	5,221.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	30	0	12,024.00	5,221.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,445.27	0.00
MED/SURG SUPPLY	4,669.97	0.00
LABORATORY-GENERAL	6,629.00	0.00
RADIOLOGY-DIAGNOSTIC	163.62	0.00
CT SCAN	2,426.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	675.92	0.00
OPERATING ROOM	122.12	0.00
LABOR/DELIVERY ROOM	2,685.82	0.00
RESPIRATORY SERVICES	4,963.24	0.00
ANESTHESIA	220.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,600.00	0.00
RECOVERY ROOM	1,643.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	155.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,708.77	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	860.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	41,968.81	0.00
TOTAL ACCOMODATIONS	12,024.00	5,221.00
TOTAL CHARGES	53,992.81	5,221.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	40,973,846.79	ADJUSTMENTS	640,058.63
COVERED CHARGES	39,638,525.46	CONTRACTUAL ALLOW	29,356,380.51
NON-COVERED CHARGES	1,335,321.33	TOTAL MEDICAID LIAB	10,282,144.95
		LESS: COB	8,561.90
		LESS: COPAYMENT	55,092.00
		REIMBURSEMENT	10,218,491.05
		ALL OTHER	9,466,900.60
		FEE SCHEDULE-LAB	751,578.56
		INJECTABLE DRUGS	11.89

TOTAL NUMBER OF CLAIMS 31,903

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,908,878.40	8,452.87
MED/SURG SUPPLY	3,337,568.15	17,724.20
LABORATORY-GENERAL	7,347.00	78,365.43
RADIOLOGY-DIAGNOSTIC	1,919,634.95	32,549.28
CT SCAN	1,652,515.00	164,053.00
PHYSICAL THERAPY	763,865.37	7,978.86
EKG/ECG	159,088.43	10,537.02
IV THERAPY	1,175,474.95	10,392.27
OPERATING ROOM	3,177,128.98	76,174.17
LABOR/DELIVERY ROOM	587,550.36	375.82
RESPIRATORY SERVICES	449,524.99	11,532.00
ANESTHESIA	311,871.79	231.00
GI SERVICES	479,997.00	9,603.00
EMERGENCY ROOM	4,181,194.39	9,656.59
RECOVERY ROOM	1,028,633.30	735.00
LABORATORY PATHOLOGIC	0.00	65.00
RADIOLOGY THERAPEUTIC	1,893,385.98	32,062.91
OCCUPATIONAL THERAPY	448,263.14	4,232.36
SPEECH PATHOLOGY	607,499.70	4,842.76
RENAL DIALYSIS	0.00	685.42
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,040,416.83	37,098.25
PSYCHIATRIC SERVICES	202,254.64	4,735.28
LITHOTRIPSY	14,216.20	0.00
OTHER IMAGING SERVICES	1,337,922.73	110,329.01
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	134,264.06	50,278.01
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	409,019.94	856.52
AUDIOLOGY	33,110.22	250.00
CARDIOLOGY	1,048,179.55	19,938.64
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	567,542.19	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,826,089.60	11,239.27
OTHER LAB SERVICES	451,590.76	537.59
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	11,970.18	2,999.90
OTHER THERAPEUTIC SERVI	0.00	3,048.19
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,959,833.86	533,614.40
MRI SERVICES	505,188.82	69,278.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	7,460.20	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43.80	4,025.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,843.30

TOTAL ANCILLARY	39,638,525.46	1,335,321.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,638,525.46	1,335,321.33

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	166,386.28	ADJUSTMENTS	0.00
COVERED CHARGES	155,402.20	CONTRACTUAL ALLOW	64,069.86
NON-COVERED CHARGES	10,984.08	TOTAL MEDICAID LIAB	91,332.34
		LESS: COB	91,065.34
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	0.00
		ALL OTHER	3,301.52-
		FEE SCHEDULE-LAB	3,301.52
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 175

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
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TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,395.30	0.00
MED/SURG SUPPLY	13,177.76	0.00
LABORATORY-GENERAL	0.00	91.00
RADIOLOGY-DIAGNOSTIC	7,522.38	0.00
CT SCAN	2,128.00	3,303.00
PHYSICAL THERAPY	11,829.87	0.00
EKG/ECG	1,840.04	0.00
IV THERAPY	6,121.97	0.00
OPERATING ROOM	11,608.68	0.00
LABOR/DELIVERY ROOM	8,634.71	0.00
RESPIRATORY SERVICES	82.44	0.00
ANESTHESIA	1,155.00	0.00
GI SERVICES	2,400.00	0.00
EMERGENCY ROOM	8,361.19	0.00
RECOVERY ROOM	4,255.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,220.00	0.00
OCCUPATIONAL THERAPY	3,036.08	296.56
SPEECH PATHOLOGY	1,237.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,347.80	1,156.49
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,261.44	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	697.00	2,058.03
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,413.64	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,415.87	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,767.30	1,000.00
OTHER LAB SERVICES	2,606.29	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	85.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,876.94	2,994.00
MRI SERVICES	3,010.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	155,402.20	10,984.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	155,402.20	10,984.08

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,182,605.87	ADJUSTMENTS	3,786.46
COVERED CHARGES	1,161,114.06	CONTRACTUAL ALLOW	1,054,022.94
NON-COVERED CHARGES	21,491.81	TOTAL MEDICAID LIAB	107,091.12
		LESS: COB	85.32
		LESS: COPAYMENT	2,532.00
		REIMBURSEMENT	104,473.80

TOTAL NUMBER OF CLAIMS 2,132

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,476.65	9.00
MED/SURG SUPPLY	68,901.44	84.98
LABORATORY-GENERAL	136,964.50	13,795.54
RADIOLOGY-DIAGNOSTIC	79,953.82	1,316.13
CT SCAN	25,442.00	2,312.00
PHYSICAL THERAPY	2,690.66	0.00
EKG/ECG	3,692.46	0.00
IV THERAPY	30,631.00	2,365.72
OPERATING ROOM	4,951.78	0.00
LABOR/DELIVERY ROOM	1,295.73	0.00
RESPIRATORY SERVICES	4,108.39	0.00
ANESTHESIA	462.00	0.00
GI SERVICES	1,200.00	0.00
EMERGENCY ROOM	647,493.36	1,242.73
RECOVERY ROOM	1,760.00	0.00
LABORATORY PATHOLOGIC	37.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	173.03	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,514.60	0.00
PSYCHIATRIC SERVICES	423.42	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	16,581.90	365.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,911.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,195.42	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,417.54	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	54,567.22	0.00
OTHER LAB SERVICES	5,500.65	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	127.49	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17.00	0.00
MRI SERVICES	1,624.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,161,114.06	21,491.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,161,114.06	21,491.81

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,726.49	ADJUSTMENTS	0.00
COVERED CHARGES	3,457.49	CONTRACTUAL ALLOW	2,356.73
NON-COVERED CHARGES	269.00	TOTAL MEDICAID LIAB	1,100.76
		LESS: COB	1,091.76
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152.80	0.00
MED/SURG SUPPLY	67.32	0.00
LABORATORY-GENERAL	365.00	99.00
RADIOLOGY-DIAGNOSTIC	463.28	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	90.06	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	156.30	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,162.73	170.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,457.49	269.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,457.49	269.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE

ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,565,431.34	ADJUSTMENTS	91,005.72
COVERED CHARGES	3,521,289.61	CONTRACTUAL ALLOW	2,801,580.24
NON-COVERED CHARGES	44,141.73	TOTAL MEDICAID LIAB	719,709.37
		LESS: COB	196.11
		LESS: COPAYMENT	3,033.00
		REIMBURSEMENT	716,480.26

TOTAL NUMBER OF CLAIMS 192

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,426,236.24	0.00
MED/SURG SUPPLY	537,752.55	1,103.89
LABORATORY-GENERAL	1,301.00	910.00
RADIOLOGY-DIAGNOSTIC	33,579.60	3,400.56
CT SCAN	12,897.00	1,500.00
PHYSICAL THERAPY	1,556.48	0.00
EKG/ECG	3,346.63	270.18
IV THERAPY	75,140.08	337.96
OPERATING ROOM	284,754.96	9,717.47
LABOR/DELIVERY ROOM	1,887.00	0.00
RESPIRATORY SERVICES	36,309.62	0.00
ANESTHESIA	26,101.31	0.00
GI SERVICES	1,200.00	0.00
EMERGENCY ROOM	10,246.96	143.28
RECOVERY ROOM	48,855.50	0.00
LABORATORY PATHOLOGIC	211.00	0.00
RADIOLOGY THERAPEUTIC	733,870.72	4,182.17
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	48,806.64	1,503.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	71,791.81	0.00
OTHER IMAGING SERVICES	12,156.41	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,124.00	1,694.06
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,413.64	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,950.42	11,293.12
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	41,235.43	658.25
OTHER LAB SERVICES	660.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	11,293.12	170.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,611.49	6,285.79
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	972.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,521,289.61	44,141.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,521,289.61	44,141.73

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W THIRD AVENUE
ALBANY GA 31701-1943

PROVIDER NUMBER 000001482A
NUMBER OF BEDS 403
TITLE XVIII NO: 11S007

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	926,531.79	ADJUSTMENTS	4,182.30
COVERED CHARGES	908,004.79	CONTRACTUAL ALLOW	303,285.05
NON-COVERED CHARGES	18,527.00	TOTAL MEDICAID LIAB	604,719.74
		LESS: COB	8,274.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	596,445.59

TOTAL NUMBER OF ADMISSIONS 188

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	457	0	151,507.00	8,092.00
NURSERY CARE CHARGES	79	0	15,946.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	536	0	167,453.00	8,092.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	536	0	167,453.00	8,092.00

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,003.49	0.00
MED/SURG SUPPLY	207,560.48	0.00
LABORATORY-GENERAL	94,116.68	0.00
RADIOLOGY-DIAGNOSTIC	18,911.00	0.00
CT SCAN	24,491.00	0.00
PHYSICAL THERAPY	728.00	0.00
EKG/ECG	3,072.00	0.00
IV THERAPY	3,228.00	0.00
OPERATING ROOM	42,908.00	0.00
LABOR/DELIVERY ROOM	35,586.00	0.00
RESPIRATORY SERVICES	44,271.00	0.00
ANESTHESIA	31,138.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,248.00	0.00
RECOVERY ROOM	13,251.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,710.14	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,545.00	7,729.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	168.00	0.00
CARDIOLOGY	1,269.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,124.00	0.00
OTHER LAB SERVICES	1,192.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,706.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	740,551.79	10,435.00
TOTAL ACCOMODATIONS	167,453.00	8,092.00
TOTAL CHARGES	908,004.79	18,527.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	24,554.85	ADJUSTMENTS	0.00
COVERED CHARGES	24,036.85	CONTRACTUAL ALLOW	2,084.24
NON-COVERED CHARGES	518.00	TOTAL MEDICAID LIAB	21,952.61
		LESS: COB	21,952.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	12	0	3,960.00	224.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	3,960.00	224.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	3,960.00	224.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,177.70	0.00
MED/SURG SUPPLY	8,132.80	0.00
LABORATORY-GENERAL	1,960.35	0.00
RADIOLOGY-DIAGNOSTIC	216.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,000.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	56.00	0.00
ANESTHESIA	798.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,182.00	0.00
RECOVERY ROOM	350.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	204.00	294.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	20,076.85	294.00
TOTAL ACCOMODATIONS	3,960.00	224.00
TOTAL CHARGES	24,036.85	518.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,068,042.21	ADJUSTMENTS	35,020.66
COVERED CHARGES	1,943,883.62	CONTRACTUAL ALLOW	786,272.42
NON-COVERED CHARGES	124,158.59	TOTAL MEDICAID LIAB	1,157,611.20
		LESS: COB	5,925.06
		LESS: COPAYMENT	2,343.00
		REIMBURSEMENT	1,149,343.14
		ALL OTHER	1,108,823.23
		FEE SCHEDULE-LAB	40,519.91
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,547

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188,899.95	5,584.99
MED/SURG SUPPLY	206,379.86	1,026.50
LABORATORY-GENERAL	0.00	11,501.80
RADIOLOGY-DIAGNOSTIC	199,762.00	5,586.00
CT SCAN	123,608.17	4,637.00
PHYSICAL THERAPY	71,371.00	7,869.00
EKG/ECG	21,332.00	128.00
IV THERAPY	26,728.00	240.00
OPERATING ROOM	23,760.00	1,000.00
LABOR/DELIVERY ROOM	6,343.00	0.00
RESPIRATORY SERVICES	27,893.00	174.00
ANESTHESIA	10,925.00	251.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	526,476.00	4,227.00
RECOVERY ROOM	7,394.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	701.00	110.00
SPEECH PATHOLOGY	11,584.00	592.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	61,240.00	2,639.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	57.00	13,738.05
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,543.60	724.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,081.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	96,177.00	12,681.00
OTHER LAB SERVICES	7,279.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	281,835.94	49,689.55
MRI SERVICES	3,535.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,520.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	977.70	82.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	157.50

TOTAL ANCILLARY	1,943,883.62	124,158.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,943,883.62	124,158.59

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	37,609.30	ADJUSTMENTS	0.00
COVERED CHARGES	34,549.35	CONTRACTUAL ALLOW	7,045.26
NON-COVERED CHARGES	3,059.95	TOTAL MEDICAID LIAB	27,504.09
		LESS: COB	27,495.09
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,274.50-
		FEE SCHEDULE-LAB	1,274.50
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,684.60	0.00
MED/SURG SUPPLY	4,797.70	0.00
LABORATORY-GENERAL	0.00	240.50
RADIOLOGY-DIAGNOSTIC	3,630.00	338.00
CT SCAN	4,864.00	0.00
PHYSICAL THERAPY	815.00	329.00
EKG/ECG	128.00	0.00
IV THERAPY	120.00	0.00
OPERATING ROOM	0.00	1,015.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	179.00	0.00
ANESTHESIA	1,111.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,769.00	120.00
RECOVERY ROOM	273.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	498.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,103.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,075.05	519.45
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	34,549.35	3,059.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,549.35	3,059.95

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	248,887.95	ADJUSTMENTS	200.00
COVERED CHARGES	246,103.90	CONTRACTUAL ALLOW	203,356.34
NON-COVERED CHARGES	2,784.05	TOTAL MEDICAID LIAB	42,747.56
		LESS: COB	166.83
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	42,358.73

TOTAL NUMBER OF CLAIMS 852

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,095.70	0.00
MED/SURG SUPPLY	15,035.75	0.00
LABORATORY-GENERAL	24,401.65	2,070.95
RADIOLOGY-DIAGNOSTIC	12,160.00	63.00
CT SCAN	1,564.00	0.00
PHYSICAL THERAPY	550.00	0.00
EKG/ECG	1,280.00	0.00
IV THERAPY	2,999.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,217.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	163,771.00	315.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,008.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	317.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.80	18.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	246,103.90	2,784.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	246,103.90	2,784.05

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,666.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,563.30	CONTRACTUAL ALLOW	1,803.33
NON-COVERED CHARGES	1,102.95	TOTAL MEDICAID LIAB	2,759.97
		LESS: COB	2,753.97
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	399.00	10.60
MED/SURG SUPPLY	326.90	0.00
LABORATORY-GENERAL	310.40	154.35
RADIOLOGY-DIAGNOSTIC	549.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,623.00	938.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	334.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,563.30	1,102.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,563.30	1,102.95

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	31,663.10	ADJUSTMENTS	0.00
COVERED CHARGES	29,483.50	CONTRACTUAL ALLOW	13,081.74
NON-COVERED CHARGES	2,179.60	TOTAL MEDICAID LIAB	16,401.76
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	16,398.76

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,374.10	0.00
MED/SURG SUPPLY	7,829.10	0.00
LABORATORY-GENERAL	0.00	10.50
RADIOLOGY-DIAGNOSTIC	1,481.00	0.00
CT SCAN	5,592.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	120.00	0.00
OPERATING ROOM	1,981.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6.00	445.00
ANESTHESIA	2,182.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,004.00	0.00
RECOVERY ROOM	273.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,641.30	1,724.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	29,483.50	2,179.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,483.50	2,179.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	730,183.90	ADJUSTMENTS	0.00
COVERED CHARGES	718,929.90	CONTRACTUAL ALLOW	224,168.49
NON-COVERED CHARGES	11,254.00	TOTAL MEDICAID LIAB	494,761.41
		LESS: COB	1,964.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	492,797.11

TOTAL NUMBER OF ADMISSIONS 156

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	395	0	137,065.00	7,617.00
NURSERY CARE CHARGES	69	0	14,490.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	464	0	151,555.00	7,617.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	464	0	151,555.00	7,617.00

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	201,271.10	0.00
MED/SURG SUPPLY	156,818.10	0.00
LABORATORY-GENERAL	83,870.00	0.00
RADIOLOGY-DIAGNOSTIC	14,419.00	0.00
CT SCAN	17,737.00	0.00
PHYSICAL THERAPY	1,050.00	0.00
EKG/ECG	4,020.00	0.00
IV THERAPY	3,018.00	0.00
OPERATING ROOM	16,024.00	0.00
LABOR/DELIVERY ROOM	28,760.00	0.00
RESPIRATORY SERVICES	4,356.00	0.00
ANESTHESIA	7,877.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,595.00	0.00
RECOVERY ROOM	4,703.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	381.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,170.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,324.00	1,016.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	484.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	534.00	0.00
OTHER LAB SERVICES	679.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,621.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	284.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	567,374.90	3,637.00
TOTAL ACCOMODATIONS	151,555.00	7,617.00
TOTAL CHARGES	718,929.90	11,254.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,395.80	ADJUSTMENTS	0.00
COVERED CHARGES	17,855.80	CONTRACTUAL ALLOW	4,675.86
NON-COVERED CHARGES	540.00	TOTAL MEDICAID LIAB	13,179.94
		LESS: COB	13,179.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8	0	2,380.00	540.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	2,380.00	540.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	2,380.00	540.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,298.60	0.00
MED/SURG SUPPLY	4,606.20	0.00
LABORATORY-GENERAL	1,715.00	0.00
RADIOLOGY-DIAGNOSTIC	288.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,374.00	0.00
LABOR/DELIVERY ROOM	1,427.00	0.00
RESPIRATORY SERVICES	224.00	0.00
ANESTHESIA	394.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	225.00	0.00
RECOVERY ROOM	709.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	215.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	15,475.80	0.00
TOTAL ACCOMODATIONS	2,380.00	540.00
TOTAL CHARGES	17,855.80	540.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,178,633.20	ADJUSTMENTS	89,647.46
COVERED CHARGES	2,079,430.40	CONTRACTUAL ALLOW	903,268.63
NON-COVERED CHARGES	99,202.80	TOTAL MEDICAID LIAB	1,176,161.77
		LESS: COB	6,425.48
		LESS: COPAYMENT	1,989.00
		REIMBURSEMENT	1,167,747.29
		ALL OTHER	1,122,673.11
		FEE SCHEDULE-LAB	45,074.18
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,577

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,047.00	97.20
MED/SURG SUPPLY	210,359.90	686.80
LABORATORY-GENERAL	685.00	7,208.40
RADIOLOGY-DIAGNOSTIC	188,552.00	2,408.00
CT SCAN	154,863.00	3,313.00
PHYSICAL THERAPY	56,498.00	232.00
EKG/ECG	19,966.00	0.00
IV THERAPY	25,426.00	0.00
OPERATING ROOM	26,678.00	2,100.00
LABOR/DELIVERY ROOM	3,962.00	194.00
RESPIRATORY SERVICES	1,039.00	0.00
ANESTHESIA	16,294.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	639,382.70	619.00
RECOVERY ROOM	7,674.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,468.00	0.00
SPEECH PATHOLOGY	9,488.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	48,514.00	509.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,421.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,723.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,245.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	135,387.20	16,124.00
OTHER LAB SERVICES	3,616.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	325,433.50	60,908.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	129.10	381.70

TOTAL ANCILLARY	2,079,430.40	99,202.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,079,430.40	99,202.80

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	26,352.10	ADJUSTMENTS	0.00
COVERED CHARGES	24,470.10	CONTRACTUAL ALLOW	4,512.78
NON-COVERED CHARGES	1,882.00	TOTAL MEDICAID LIAB	19,957.32
		LESS: COB	19,930.32
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	552.67-
		FEE SCHEDULE-LAB	552.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,390.50	0.00
MED/SURG SUPPLY	2,080.60	0.00
LABORATORY-GENERAL	0.00	21.00
RADIOLOGY-DIAGNOSTIC	3,274.00	559.00
CT SCAN	1,888.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	629.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,679.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	882.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,093.00	597.00
OTHER LAB SERVICES	425.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,129.00	705.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	24,470.10	1,882.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,470.10	1,882.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	276,523.30	ADJUSTMENTS	2,005.00
COVERED CHARGES	273,292.30	CONTRACTUAL ALLOW	231,092.30
NON-COVERED CHARGES	3,231.00	TOTAL MEDICAID LIAB	42,200.00
		LESS: COB	21.88
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	41,509.12

TOTAL NUMBER OF CLAIMS 844

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,965.40	0.00
MED/SURG SUPPLY	15,394.80	0.00
LABORATORY-GENERAL	26,092.00	3,231.00
RADIOLOGY-DIAGNOSTIC	10,771.00	0.00
CT SCAN	4,769.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,206.00	0.00
IV THERAPY	3,146.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	189,861.10	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	294.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	368.00	0.00
OTHER LAB SERVICES	425.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	273,292.30	3,231.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	273,292.30	3,231.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,921.30	ADJUSTMENTS	0.00
COVERED CHARGES	2,881.30	CONTRACTUAL ALLOW	1,308.31
NON-COVERED CHARGES	40.00	TOTAL MEDICAID LIAB	1,572.99
		LESS: COB	1,572.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204.40	0.00
MED/SURG SUPPLY	161.90	0.00
LABORATORY-GENERAL	310.00	40.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,205.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,881.30	40.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,881.30	40.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	40,626.50	ADJUSTMENTS	4,100.44
COVERED CHARGES	38,564.90	CONTRACTUAL ALLOW	22,163.14
NON-COVERED CHARGES	2,061.60	TOTAL MEDICAID LIAB	16,401.76
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	16,395.76

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,257.90	37.60
MED/SURG SUPPLY	7,913.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	134.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,725.00	1,127.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	96.00	0.00
ANESTHESIA	3,263.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,077.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	702.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	84.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,122.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,275.00	462.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	351.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	38,564.90	2,061.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,564.90	2,061.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	253,477.00	ADJUSTMENTS	9,121.64
COVERED CHARGES	247,286.00	CONTRACTUAL ALLOW	64,921.51
NON-COVERED CHARGES	6,191.00	TOTAL MEDICAID LIAB	182,364.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	182,364.49

TOTAL NUMBER OF ADMISSIONS 53

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	133	0	46,479.00	5,345.00
NURSERY CARE CHARGES	19	0	4,237.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	152	0	50,716.00	5,345.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	152	0	50,716.00	5,345.00

INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,335.00	0.00
MED/SURG SUPPLY	51,067.00	0.00
LABORATORY-GENERAL	32,012.00	0.00
RADIOLOGY-DIAGNOSTIC	5,792.00	0.00
CT SCAN	6,530.00	0.00
PHYSICAL THERAPY	382.00	0.00
EKG/ECG	1,278.00	0.00
IV THERAPY	604.00	0.00
OPERATING ROOM	10,021.00	0.00
LABOR/DELIVERY ROOM	6,284.00	0.00
RESPIRATORY SERVICES	2,240.00	0.00
ANESTHESIA	6,222.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,929.00	0.00
RECOVERY ROOM	2,672.00	0.00
LABORATORY PATHOLOGIC	788.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,589.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	240.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	141.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	910.00	0.00
OTHER LAB SERVICES	489.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	846.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	196,570.00	846.00
TOTAL ACCOMODATIONS	50,716.00	5,345.00
TOTAL CHARGES	247,286.00	6,191.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,093.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,991.00	CONTRACTUAL ALLOW	886.95
NON-COVERED CHARGES	102.00	TOTAL MEDICAID LIAB	4,104.05
		LESS: COB	4,104.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	694.00	102.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	694.00	102.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	694.00	102.00

ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	579.00	0.00
MED/SURG SUPPLY	396.00	0.00
LABORATORY-GENERAL	1,246.00	0.00
RADIOLOGY-DIAGNOSTIC	268.00	0.00
CT SCAN	1,808.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,297.00	0.00
TOTAL ACCOMODATIONS	694.00	102.00
TOTAL CHARGES	4,991.00	102.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,117,088.13	ADJUSTMENTS	65,204.00
COVERED CHARGES	2,001,592.47	CONTRACTUAL ALLOW	888,647.57
NON-COVERED CHARGES	115,495.66	TOTAL MEDICAID LIAB	1,112,944.90
		LESS: COB	3,831.33
		LESS: COPAYMENT	1,887.00
		REIMBURSEMENT	1,107,226.57
		ALL OTHER	1,067,367.08
		FEE SCHEDULE-LAB	39,626.49
		INJECTABLE DRUGS	233.00

TOTAL NUMBER OF CLAIMS 3,501

OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,372.36	1,471.00
MED/SURG SUPPLY	141,341.69	189.00
LABORATORY-GENERAL	1,064.00	7,963.00
RADIOLOGY-DIAGNOSTIC	177,731.00	1,731.00
CT SCAN	86,435.00	12,904.00
PHYSICAL THERAPY	61,113.00	10,521.00
EKG/ECG	22,865.00	0.00
IV THERAPY	34,672.00	2,294.00
OPERATING ROOM	12,934.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,423.60	0.00
ANESTHESIA	6,602.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	694,041.00	2,552.00
RECOVERY ROOM	3,120.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	14,698.00	366.00
SPEECH PATHOLOGY	14,542.00	332.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	50,196.00	339.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,466.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,112.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	26,545.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	168,634.82	16,811.00
OTHER LAB SERVICES	5,474.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	304,106.00	55,550.66
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	411.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	159.00	6.00

TOTAL ANCILLARY	2,001,592.47	115,495.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,001,592.47	115,495.66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	28,993.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,432.00	CONTRACTUAL ALLOW	1,545.95
NON-COVERED CHARGES	5,561.00	TOTAL MEDICAID LIAB	21,886.05
		LESS: COB	21,754.05
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	0.00
		ALL OTHER	775.83-
		FEE SCHEDULE-LAB	775.83
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,297.00	0.00
MED/SURG SUPPLY	1,292.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,744.00	407.00
CT SCAN	0.00	3,664.00
PHYSICAL THERAPY	1,291.00	576.00
EKG/ECG	0.00	0.00
IV THERAPY	717.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,598.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	339.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,154.00	914.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	23,432.00	5,561.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,432.00	5,561.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	323,158.42	ADJUSTMENTS	985.00
COVERED CHARGES	318,460.42	CONTRACTUAL ALLOW	271,210.42
NON-COVERED CHARGES	4,698.00	TOTAL MEDICAID LIAB	47,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	981.00
		REIMBURSEMENT	46,269.00

TOTAL NUMBER OF CLAIMS 945

OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,198.42	0.00
MED/SURG SUPPLY	14,172.00	0.00
LABORATORY-GENERAL	32,557.00	3,505.00
RADIOLOGY-DIAGNOSTIC	10,869.00	0.00
CT SCAN	4,245.00	990.00
PHYSICAL THERAPY	157.00	64.00
EKG/ECG	1,562.00	0.00
IV THERAPY	3,629.00	139.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	217.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	229,965.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	404.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,480.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	318,460.42	4,698.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	318,460.42	4,698.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,188.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,794.00	CONTRACTUAL ALLOW	2,440.65
NON-COVERED CHARGES	394.00	TOTAL MEDICAID LIAB	2,353.35
		LESS: COB	2,350.35
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312.00	0.00
MED/SURG SUPPLY	21.00	0.00
LABORATORY-GENERAL	557.00	44.00
RADIOLOGY-DIAGNOSTIC	252.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,652.00	350.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,794.00	394.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,794.00	394.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	75,852.00	ADJUSTMENTS	7,016.96
COVERED CHARGES	69,593.00	CONTRACTUAL ALLOW	38,003.18
NON-COVERED CHARGES	6,259.00	TOTAL MEDICAID LIAB	31,589.82
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	31,565.82

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,066.00	696.00
MED/SURG SUPPLY	6,732.00	857.00
LABORATORY-GENERAL	0.00	2,708.00
RADIOLOGY-DIAGNOSTIC	914.00	125.00
CT SCAN	6,338.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,357.00	0.00
OPERATING ROOM	1,670.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	860.00	0.00
ANESTHESIA	1,264.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,280.00	0.00
RECOVERY ROOM	751.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	404.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,098.00	1,090.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,859.00	783.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	69,593.00	6,259.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,593.00	6,259.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH HOSPITAL
DBA PHOEBE WORTH MEDICAL CTR
807 SOUTH ISABELLA STREET
SYLVESTER GA 31791-7554

PROVIDER NUMBER 000002109A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP40

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	254,436.61	ADJUSTMENTS	0.00
COVERED CHARGES	253,011.61	CONTRACTUAL ALLOW	101,269.03
NON-COVERED CHARGES	1,425.00	TOTAL MEDICAID LIAB	151,742.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	151,742.58

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	108	0	28,944.00	1,425.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	108	0	28,944.00	1,425.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	108	0	28,944.00	1,425.00

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,184.21	0.00
MED/SURG SUPPLY	12,875.00	0.00
LABORATORY-GENERAL	67,290.00	0.00
RADIOLOGY-DIAGNOSTIC	11,360.00	0.00
CT SCAN	22,911.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,700.00	0.00
IV THERAPY	4,014.00	0.00
OPERATING ROOM	1,109.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,974.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	507.00	0.00
EMERGENCY ROOM	15,285.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,477.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,098.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	431.79	0.00
OTHER LAB SERVICES	800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	51.61	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	224,067.61	0.00
TOTAL ACCOMODATIONS	28,944.00	1,425.00
TOTAL CHARGES	253,011.61	1,425.00

ZERO PAID INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,466,841.29	ADJUSTMENTS	11,472.43
COVERED CHARGES	3,282,299.92	CONTRACTUAL ALLOW	2,219,081.03
NON-COVERED CHARGES	184,541.37	TOTAL MEDICAID LIAB	1,063,218.89
		LESS: COB	1,631.26
		LESS: COPAYMENT	5,235.00
		REIMBURSEMENT	1,056,352.63
		ALL OTHER	976,825.18
		FEE SCHEDULE-LAB	79,518.43
		INJECTABLE DRUGS	9.02

TOTAL NUMBER OF CLAIMS 5,698

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,518.52	878.16
MED/SURG SUPPLY	102,991.00	402.00
LABORATORY-GENERAL	0.00	1,642.00
RADIOLOGY-DIAGNOSTIC	428,771.00	4,989.00
CT SCAN	317,621.00	6,785.00
PHYSICAL THERAPY	98,149.00	11,195.00
EKG/ECG	39,500.00	0.00
IV THERAPY	70,671.00	0.00
OPERATING ROOM	8,255.00	197.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,829.00	5.00
ANESTHESIA	2,042.00	0.00
GI SERVICES	2,669.50	3,348.50
EMERGENCY ROOM	1,003,800.00	3,171.00
RECOVERY ROOM	1,641.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	147.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,442.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	67,923.00	1,860.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	203.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,777.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,053.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,595.58	178.39
OTHER LAB SERVICES	9,896.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	825,065.35	147,959.50
MRI SERVICES	31,394.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	137.97	114.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	24.00

TOTAL ANCILLARY	3,282,299.92	184,541.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,282,299.92	184,541.37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	89,266.21	ADJUSTMENTS	0.00
COVERED CHARGES	81,904.21	CONTRACTUAL ALLOW	17,125.81
NON-COVERED CHARGES	7,362.00	TOTAL MEDICAID LIAB	64,778.40
		LESS: COB	64,694.40
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,676.68-
		FEE SCHEDULE-LAB	1,676.68
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,616.21	0.00
MED/SURG SUPPLY	1,822.00	0.00
LABORATORY-GENERAL	0.00	171.00
RADIOLOGY-DIAGNOSTIC	9,520.00	879.00
CT SCAN	16,116.00	0.00
PHYSICAL THERAPY	4,592.00	104.00
EKG/ECG	1,246.00	0.00
IV THERAPY	636.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,856.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	24.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,365.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	877.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,228.00	6,184.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	81,904.21	7,362.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,904.21	7,362.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	607,958.61	ADJUSTMENTS	451.04
COVERED CHARGES	591,159.76	CONTRACTUAL ALLOW	502,659.76
NON-COVERED CHARGES	16,798.85	TOTAL MEDICAID LIAB	88,500.00
		LESS: COB	295.52
		LESS: COPAYMENT	1,527.00
		REIMBURSEMENT	86,677.48

TOTAL NUMBER OF CLAIMS 1,770

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,883.45	471.85
MED/SURG SUPPLY	7,754.00	67.00
LABORATORY-GENERAL	104,309.00	13,182.00
RADIOLOGY-DIAGNOSTIC	64,423.00	544.00
CT SCAN	28,886.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,408.00	184.00
IV THERAPY	5,652.00	318.00
OPERATING ROOM	324.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,526.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	331,398.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	48.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	486.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	220.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	105.03	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.28	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,764.00

TOTAL ANCILLARY	591,159.76	16,798.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	591,159.76	16,798.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,439.60	ADJUSTMENTS	0.00
COVERED CHARGES	6,836.60	CONTRACTUAL ALLOW	4,437.98
NON-COVERED CHARGES	1,603.00	TOTAL MEDICAID LIAB	2,398.62
		LESS: COB	2,383.62
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	839.60	0.00
MED/SURG SUPPLY	189.00	0.00
LABORATORY-GENERAL	1,933.00	387.00
RADIOLOGY-DIAGNOSTIC	504.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	184.00	0.00
IV THERAPY	318.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	36.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,833.00	1,216.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,836.60	1,603.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,836.60	1,603.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,334.82	ADJUSTMENTS	0.00
COVERED CHARGES	11,096.82	CONTRACTUAL ALLOW	7,014.73
NON-COVERED CHARGES	2,238.00	TOTAL MEDICAID LIAB	4,082.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,082.09

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,989.01	0.00
MED/SURG SUPPLY	270.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	324.00	0.00
CT SCAN	3,427.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	318.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	655.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,009.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,240.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	501.81	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	363.00	2,238.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,096.82	2,238.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,096.82	2,238.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	262,975.24	ADJUSTMENTS	0.00
COVERED CHARGES	261,515.24	CONTRACTUAL ALLOW	126,429.01
NON-COVERED CHARGES	1,460.00	TOTAL MEDICAID LIAB	135,086.23
		LESS: COB	2,019.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	133,066.60

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	110	0	29,480.00	750.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	110	0	29,480.00	750.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	110	0	29,480.00	750.00

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,646.64	0.00
MED/SURG SUPPLY	14,360.00	0.00
LABORATORY-GENERAL	54,249.00	0.00
RADIOLOGY-DIAGNOSTIC	7,699.00	0.00
CT SCAN	19,221.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,593.00	0.00
IV THERAPY	4,128.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,692.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,343.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,030.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	476.00	710.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,340.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	911.93	0.00
OTHER LAB SERVICES	864.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,481.67	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	232,035.24	710.00
TOTAL ACCOMODATIONS	29,480.00	750.00
TOTAL CHARGES	261,515.24	1,460.00

ZERO PAID INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,660,918.90	ADJUSTMENTS	52,948.14
COVERED CHARGES	3,540,817.14	CONTRACTUAL ALLOW	2,296,983.77
NON-COVERED CHARGES	120,101.76	TOTAL MEDICAID LIAB	1,243,833.37
		LESS: COB	423.18
		LESS: COPAYMENT	2,313.00
		REIMBURSEMENT	1,241,097.19
		ALL OTHER	1,155,642.66
		FEE SCHEDULE-LAB	82,675.86
		INJECTABLE DRUGS	2,778.67

TOTAL NUMBER OF CLAIMS 5,809

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	174,826.19	44.89
MED/SURG SUPPLY	70,560.00	408.00
LABORATORY-GENERAL	0.00	1,066.00
RADIOLOGY-DIAGNOSTIC	440,803.00	3,948.00
CT SCAN	542,837.00	7,340.00
PHYSICAL THERAPY	106,258.00	2,916.00
EKG/ECG	37,931.00	0.00
IV THERAPY	57,710.00	0.00
OPERATING ROOM	100.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,222.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,086,426.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	159.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,572.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,020.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,273.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,555.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,037.06	0.00
OTHER LAB SERVICES	8,200.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	828,266.52	100,697.00
MRI SERVICES	43,332.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,301.37	2,109.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,540,817.14	120,101.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,540,817.14	120,101.76

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,275.85	ADJUSTMENTS	0.00
COVERED CHARGES	19,153.85	CONTRACTUAL ALLOW	4,792.62
NON-COVERED CHARGES	122.00	TOTAL MEDICAID LIAB	14,361.23
		LESS: COB	14,358.23
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	269.53-
		FEE SCHEDULE-LAB	260.90
		INJECTABLE DRUGS	8.63

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	515.26	0.00
MED/SURG SUPPLY	169.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,754.00	0.00
CT SCAN	7,458.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	318.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	96.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,337.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,085.00	122.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.59	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,153.85	122.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,153.85	122.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	615,767.49	ADJUSTMENTS	3,611.00
COVERED CHARGES	610,427.57	CONTRACTUAL ALLOW	526,577.57
NON-COVERED CHARGES	5,339.92	TOTAL MEDICAID LIAB	83,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,089.00
		REIMBURSEMENT	82,761.00

TOTAL NUMBER OF CLAIMS 1,677

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,086.55	0.00
MED/SURG SUPPLY	6,376.00	70.00
LABORATORY-GENERAL	118,859.00	4,834.00
RADIOLOGY-DIAGNOSTIC	53,105.00	111.00
CT SCAN	46,146.00	0.00
PHYSICAL THERAPY	8,303.00	0.00
EKG/ECG	3,368.00	0.00
IV THERAPY	6,406.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,756.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	333,860.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	52.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,619.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,543.02	272.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	610,427.57	5,339.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	610,427.57	5,339.92

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,255.49	ADJUSTMENTS	0.00
COVERED CHARGES	5,255.49	CONTRACTUAL ALLOW	4,393.60
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	861.89
		LESS: COB	858.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364.38	0.00
MED/SURG SUPPLY	110.00	0.00
LABORATORY-GENERAL	915.00	0.00
RADIOLOGY-DIAGNOSTIC	1,275.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	199.00	0.00
IV THERAPY	344.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	92.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,952.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,255.49	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,255.49	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,646.50	ADJUSTMENTS	0.00
COVERED CHARGES	11,461.50	CONTRACTUAL ALLOW	7,379.41
NON-COVERED CHARGES	185.00	TOTAL MEDICAID LIAB	4,082.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,082.09

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,282.98	0.00
MED/SURG SUPPLY	331.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.00	0.00
CT SCAN	5,987.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	338.00	0.00
IV THERAPY	344.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	708.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	478.47	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,367.00	185.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,461.50	185.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,461.50	185.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	192,543.51	ADJUSTMENTS	9,266.84
COVERED CHARGES	192,358.51	CONTRACTUAL ALLOW	96,314.59
NON-COVERED CHARGES	185.00	TOTAL MEDICAID LIAB	96,043.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	96,043.92

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	91	0	24,388.00	185.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	91	0	24,388.00	185.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	91	0	24,388.00	185.00

INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,267.45	0.00
MED/SURG SUPPLY	11,736.00	0.00
LABORATORY-GENERAL	36,837.00	0.00
RADIOLOGY-DIAGNOSTIC	5,307.00	0.00
CT SCAN	13,951.00	0.00
PHYSICAL THERAPY	291.00	0.00
EKG/ECG	1,807.00	0.00
IV THERAPY	1,116.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,071.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	673.00	0.00
EMERGENCY ROOM	15,317.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,275.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,448.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,473.12	0.00
OTHER LAB SERVICES	467.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,933.94	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	167,970.51	0.00
TOTAL ACCOMODATIONS	24,388.00	185.00
TOTAL CHARGES	192,358.51	185.00

ZERO PAID INPATIENT PAID CLAIMS

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,349,676.41	ADJUSTMENTS	53,156.07
COVERED CHARGES	3,200,925.10	CONTRACTUAL ALLOW	1,972,918.62
NON-COVERED CHARGES	148,751.31	TOTAL MEDICAID LIAB	1,228,006.48
		LESS: COB	2,245.32
		LESS: COPAYMENT	2,436.00
		REIMBURSEMENT	1,223,325.16
		ALL OTHER	1,158,139.79
		FEE SCHEDULE-LAB	60,168.13
		INJECTABLE DRUGS	5,017.24

TOTAL NUMBER OF CLAIMS 4,836

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,308.61	0.00
MED/SURG SUPPLY	71,722.00	0.00
LABORATORY-GENERAL	0.00	800.00
RADIOLOGY-DIAGNOSTIC	434,002.00	6,908.00
CT SCAN	388,960.00	23,561.00
PHYSICAL THERAPY	107,531.00	0.00
EKG/ECG	36,855.00	0.00
IV THERAPY	29,760.00	372.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,332.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,109,659.00	618.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,206.00	1,112.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	145.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,010.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,323.00	388.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	24,685.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,500.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,088.11	0.00
OTHER LAB SERVICES	7,524.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	678,665.28	111,040.84
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,794.10	3,797.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	9.30

TOTAL ANCILLARY	3,200,925.10	148,751.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,200,925.10	148,751.31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	12,813.61	ADJUSTMENTS	0.00
COVERED CHARGES	11,290.61	CONTRACTUAL ALLOW	5,679.51
NON-COVERED CHARGES	1,523.00	TOTAL MEDICAID LIAB	5,611.10
		LESS: COB	5,608.10
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	207.37-
		FEE SCHEDULE-LAB	180.29
		INJECTABLE DRUGS	27.08

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	680.60	0.00
MED/SURG SUPPLY	357.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,475.00	508.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	430.00	0.00
IV THERAPY	372.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,396.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,508.00	1,015.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64.01	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,290.61	1,523.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,290.61	1,523.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	881,466.45	ADJUSTMENTS	2,305.00
COVERED CHARGES	862,878.09	CONTRACTUAL ALLOW	761,678.09
NON-COVERED CHARGES	18,588.36	TOTAL MEDICAID LIAB	101,200.00
		LESS: COB	40.00
		LESS: COPAYMENT	1,734.00
		REIMBURSEMENT	99,426.00

TOTAL NUMBER OF CLAIMS 2,024

OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,900.17	587.05
MED/SURG SUPPLY	8,745.00	76.00
LABORATORY-GENERAL	170,589.00	6,307.00
RADIOLOGY-DIAGNOSTIC	58,451.00	0.00
CT SCAN	67,798.00	10,308.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,730.00	0.00
IV THERAPY	6,324.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,265.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	486,677.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,306.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,896.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	514.44	0.00
OTHER LAB SERVICES	934.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	226.56
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,748.48	1,083.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	862,878.09	18,588.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	862,878.09	18,588.36

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,730.09	ADJUSTMENTS	0.00
COVERED CHARGES	5,730.09	CONTRACTUAL ALLOW	4,332.68
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	1,397.41
		LESS: COB	1,394.41
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.27	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	914.00	0.00
RADIOLOGY-DIAGNOSTIC	228.00	0.00
CT SCAN	2,209.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,082.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	202.22	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,730.09	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,730.09	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.

CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,605.56	ADJUSTMENTS	3,494.27
COVERED CHARGES	9,349.56	CONTRACTUAL ALLOW	5,855.29
NON-COVERED CHARGES	1,256.00	TOTAL MEDICAID LIAB	3,494.27
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,494.27

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP10

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	479.14	0.00
MED/SURG SUPPLY	139.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228.00	0.00
CT SCAN	5,812.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	215.00	0.00
IV THERAPY	372.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	561.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	303.42	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,232.00	1,256.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,349.56	1,256.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,349.56	1,256.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLUMBIA POLK GENERAL HOSPITAL INC
424 N MAIN ST.
CEDARTOWN GA 30125-2644

PROVIDER NUMBER 000001526A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP10

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	439,385.11	ADJUSTMENTS	3,492.67
COVERED CHARGES	426,176.11	CONTRACTUAL ALLOW	47,861.11
NON-COVERED CHARGES	13,209.00	TOTAL MEDICAID LIAB	378,315.00
		LESS: COB	4,726.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	373,588.49

TOTAL NUMBER OF ADMISSIONS 101

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	253	0	75,900.00	1,025.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	253	0	75,900.00	1,025.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	17	0	11,050.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	11,050.00	0.00
TOTAL ACCOMODATIONS	270	0	86,950.00	1,025.00

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124,288.14	0.00
MED/SURG SUPPLY	49,260.74	0.00
LABORATORY-GENERAL	67,529.16	0.00
RADIOLOGY-DIAGNOSTIC	14,464.39	0.00
CT SCAN	25,775.00	0.00
PHYSICAL THERAPY	176.80	0.00
EKG/ECG	5,319.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	16,868.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,461.36	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,630.00	0.00
RECOVERY ROOM	4,215.12	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	104.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,065.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	280.80	12,184.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,862.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,839.20	0.00
OTHER LAB SERVICES	4,086.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	339,226.11	12,184.00
TOTAL ACCOMODATIONS	86,950.00	1,025.00
TOTAL CHARGES	426,176.11	13,209.00

ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	994,825.34	ADJUSTMENTS	5,517.06
COVERED CHARGES	908,228.84	CONTRACTUAL ALLOW	380,638.68
NON-COVERED CHARGES	86,596.50	TOTAL MEDICAID LIAB	527,590.16
		LESS: COB	1,502.14
		LESS: COPAYMENT	2,682.00
		REIMBURSEMENT	523,406.02
		ALL OTHER	487,146.87
		FEE SCHEDULE-LAB	36,259.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,048

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,407.16	2,050.00
MED/SURG SUPPLY	54,252.31	1,082.02
LABORATORY-GENERAL	332.80	2,473.12
RADIOLOGY-DIAGNOSTIC	100,085.00	2,994.00
CT SCAN	169,975.00	5,800.00
PHYSICAL THERAPY	12,906.40	1,300.00
EKG/ECG	10,176.40	400.40
IV THERAPY	0.00	0.00
OPERATING ROOM	37,474.40	5,160.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,444.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	115,120.80	184.00
RECOVERY ROOM	15,054.00	602.16
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	10,137.40	730.60
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,610.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	41,196.00	4,024.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,590.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,393.00	775.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,020.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,126.40	904.80
OTHER LAB SERVICES	3,460.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	104.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	187,070.11	33,683.66
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	882.96	21,192.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	908,228.84	85,946.50
TOTAL ACCOMODATIONS	0.00	650.00
TOTAL CHARGES	908,228.84	86,596.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,291.19	ADJUSTMENTS	0.00
COVERED CHARGES	12,896.15	CONTRACTUAL ALLOW	1,924.47
NON-COVERED CHARGES	1,395.04	TOTAL MEDICAID LIAB	10,971.68
		LESS: COB	10,935.68
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	732.92-
		FEE SCHEDULE-LAB	732.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,074.80	0.00
MED/SURG SUPPLY	594.27	38.48
LABORATORY-GENERAL	0.00	68.64
RADIOLOGY-DIAGNOSTIC	1,287.00	0.00
CT SCAN	3,790.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	218.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,268.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	26.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	436.80	104.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,226.08	860.08
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	297.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,896.15	1,395.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,896.15	1,395.04

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	66,742.97	ADJUSTMENTS	97.00
COVERED CHARGES	62,480.67	CONTRACTUAL ALLOW	38,480.67
NON-COVERED CHARGES	4,262.30	TOTAL MEDICAID LIAB	24,000.00
		LESS: COB	19.80
		LESS: COPAYMENT	558.00
		REIMBURSEMENT	23,422.20

TOTAL NUMBER OF CLAIMS 480

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,080.68	0.00
MED/SURG SUPPLY	1,768.75	45.76
LABORATORY-GENERAL	9,754.64	533.52
RADIOLOGY-DIAGNOSTIC	5,243.00	333.00
CT SCAN	8,465.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	270.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,981.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	917.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,350.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	62,480.67	4,262.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,480.67	4,262.30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,773.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,537.24	CONTRACTUAL ALLOW	1,650.23
NON-COVERED CHARGES	3,235.76	TOTAL MEDICAID LIAB	887.01
		LESS: COB	884.01
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234.00	220.48
MED/SURG SUPPLY	400.52	79.04
LABORATORY-GENERAL	892.32	417.04
RADIOLOGY-DIAGNOSTIC	194.00	236.00
CT SCAN	0.00	1,940.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	816.40	104.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	239.20
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,537.24	3,235.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,537.24	3,235.76

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY

EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	101,097.54	ADJUSTMENTS	4,049.98
COVERED CHARGES	98,183.33	CONTRACTUAL ALLOW	53,643.32
NON-COVERED CHARGES	2,914.21	TOTAL MEDICAID LIAB	44,540.01
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	44,528.01

TOTAL NUMBER OF CLAIMS 11

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,003.60	0.00
MED/SURG SUPPLY	29,429.77	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	944.00	428.00
CT SCAN	5,700.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	67.60	67.60
IV THERAPY	0.00	0.00
OPERATING ROOM	13,852.80	2.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79.04	49.53
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	4,616.56	1,605.76
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	30,969.20	0.00
OTHER IMAGING SERVICES	667.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,237.60	0.00
OTHER LAB SERVICES	650.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	966.16	517.92
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	243.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	98,183.33	2,914.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	98,183.33	2,914.21

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
101 LAKE OCONEE PARKWAY	000001537A	50	SERVICE DATES 10/01/2003 THROUGH 09/30/2004
	TITLE XVIII NO: HOSP11		
EATONTON GA 31024-6054			

****** NO DATA ******

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	296,602.16	ADJUSTMENTS	21,751.96
COVERED CHARGES	289,428.16	CONTRACTUAL ALLOW	15,376.01
NON-COVERED CHARGES	7,174.00	TOTAL MEDICAID LIAB	274,052.15
		LESS: COB	2,912.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	271,139.60

TOTAL NUMBER OF ADMISSIONS 78

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	197	0	59,100.00	2,500.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	197	0	59,100.00	2,500.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	1,950.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,950.00	0.00
TOTAL ACCOMODATIONS	200	0	61,050.00	2,500.00

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,430.98	0.00
MED/SURG SUPPLY	29,908.31	0.00
LABORATORY-GENERAL	50,546.61	0.00
RADIOLOGY-DIAGNOSTIC	12,462.50	0.00
CT SCAN	10,540.00	0.00
PHYSICAL THERAPY	603.20	0.00
EKG/ECG	941.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,242.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,573.99	0.00
ANESTHESIA	1,076.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,239.17	0.00
RECOVERY ROOM	3,010.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	104.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,790.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,674.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,051.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,258.00	0.00
OTHER LAB SERVICES	600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	228,378.16	4,674.00
TOTAL ACCOMODATIONS	61,050.00	2,500.00
TOTAL CHARGES	289,428.16	7,174.00

ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,344.47	ADJUSTMENTS	0.00
COVERED CHARGES	19,156.47	CONTRACTUAL ALLOW	648.00-
NON-COVERED CHARGES	1,188.00	TOTAL MEDICAID LIAB	19,804.47
		LESS: COB	19,804.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18	0	5,400.00	450.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18	0	5,400.00	450.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	18	0	5,400.00	450.00

ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,308.36	0.00
MED/SURG SUPPLY	730.11	0.00
LABORATORY-GENERAL	3,842.80	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00
CT SCAN	800.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	317.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	738.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,533.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,756.47	738.00
TOTAL ACCOMODATIONS	5,400.00	450.00
TOTAL CHARGES	19,156.47	1,188.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	960,956.22	ADJUSTMENTS	36,788.33
COVERED CHARGES	915,704.95	CONTRACTUAL ALLOW	379,661.06
NON-COVERED CHARGES	45,251.27	TOTAL MEDICAID LIAB	536,043.89
		LESS: COB	2,818.69
		LESS: COPAYMENT	1,299.00
		REIMBURSEMENT	531,926.20
		ALL OTHER	485,471.11
		FEE SCHEDULE-LAB	39,324.91
		INJECTABLE DRUGS	7,130.18

TOTAL NUMBER OF CLAIMS 2,914

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,205.00	1,312.80
MED/SURG SUPPLY	49,918.71	806.00
LABORATORY-GENERAL	499.20	1,440.40
RADIOLOGY-DIAGNOSTIC	102,454.72	1,011.00
CT SCAN	150,690.00	2,990.00
PHYSICAL THERAPY	13,795.60	218.40
EKG/ECG	9,256.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,398.83	2.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,581.15	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	131,756.15	424.58
RECOVERY ROOM	13,247.52	1,405.04
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	4,264.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,358.66	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	47,656.00	2,315.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	26.00	3,082.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,408.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	36,452.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,969.10	0.00
OTHER LAB SERVICES	8,931.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	104.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	189,314.37	27,880.61
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,418.94	2,363.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	915,704.95	45,251.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	915,704.95	45,251.27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	22,287.60	ADJUSTMENTS	0.00
COVERED CHARGES	18,398.92	CONTRACTUAL ALLOW	37.70-
NON-COVERED CHARGES	3,888.68	TOTAL MEDICAID LIAB	18,436.62
		LESS: COB	18,397.62
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		ALL OTHER	992.85-
		FEE SCHEDULE-LAB	852.46
		INJECTABLE DRUGS	140.39

TOTAL NUMBER OF CLAIMS 50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,727.20	0.00
MED/SURG SUPPLY	1,907.19	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,380.00	0.00
CT SCAN	4,780.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	135.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	1,211.60
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	122.33	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,866.88	0.00
RECOVERY ROOM	401.44	1,204.32
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,128.00	361.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	270.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,475.12	1,018.16
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	205.16	93.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,398.92	3,888.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,398.92	3,888.68

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	60,041.12	ADJUSTMENTS	535.00
COVERED CHARGES	58,554.24	CONTRACTUAL ALLOW	37,307.24
NON-COVERED CHARGES	1,486.88	TOTAL MEDICAID LIAB	21,247.00
		LESS: COB	131.88
		LESS: COPAYMENT	447.00
		REIMBURSEMENT	20,668.12

TOTAL NUMBER OF CLAIMS 425

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,181.96	0.00
MED/SURG SUPPLY	1,442.92	162.24
LABORATORY-GENERAL	12,577.76	1,100.32
RADIOLOGY-DIAGNOSTIC	3,928.00	0.00
CT SCAN	4,660.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	894.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	255.06	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,316.96	36.92
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	310.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	532.24	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,454.94	187.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	58,554.24	1,486.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,554.24	1,486.88

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	197.58	ADJUSTMENTS	0.00
COVERED CHARGES	197.58	CONTRACTUAL ALLOW	132.40
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	65.18
		LESS: COB	59.18
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51.20	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	132.86	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	197.58	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	197.58	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY

EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	101,539.26	ADJUSTMENTS	4,046.98
COVERED CHARGES	99,797.78	CONTRACTUAL ALLOW	59,310.75
NON-COVERED CHARGES	1,741.48	TOTAL MEDICAID LIAB	40,487.03
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	40,472.03

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,780.88	767.60
MED/SURG SUPPLY	26,215.38	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,216.00	170.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	202.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	10,043.20	1.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	4,215.12	802.88
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	50,172.80	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	135.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	748.80	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	67.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	99,797.78	1,741.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,797.78	1,741.48

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	431,449.01	ADJUSTMENTS	20,343.78
COVERED CHARGES	424,657.01	CONTRACTUAL ALLOW	4,169.71
NON-COVERED CHARGES	6,792.00	TOTAL MEDICAID LIAB	420,487.30
		LESS: COB	1,433.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	419,054.17

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	293	0	89,875.00	5,350.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	293	0	89,875.00	5,350.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	12	0	7,800.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	12	0	7,800.00	0.00
TOTAL ACCOMODATIONS	305	0	97,675.00	5,350.00

INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,850.12	0.00
MED/SURG SUPPLY	36,114.90	0.00
LABORATORY-GENERAL	75,173.19	0.00
RADIOLOGY-DIAGNOSTIC	12,147.00	0.00
CT SCAN	34,500.00	0.00
PHYSICAL THERAPY	374.40	0.00
EKG/ECG	7,217.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,336.68	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	24,155.01	0.00
ANESTHESIA	1,076.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,205.77	0.00
RECOVERY ROOM	1,806.48	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	31.20	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,306.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,419.60	1,442.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,265.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,841.46	0.00
OTHER LAB SERVICES	1,610.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	551.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	326,982.01	1,442.00
TOTAL ACCOMODATIONS	97,675.00	5,350.00
TOTAL CHARGES	424,657.01	6,792.00

ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,060,420.22	ADJUSTMENTS	21,130.60
COVERED CHARGES	928,702.67	CONTRACTUAL ALLOW	404,498.13
NON-COVERED CHARGES	131,717.55	TOTAL MEDICAID LIAB	524,204.54
		LESS: COB	1,209.51
		LESS: COPAYMENT	1,677.00
		REIMBURSEMENT	521,318.03
		ALL OTHER	468,555.92
		FEE SCHEDULE-LAB	45,878.74
		INJECTABLE DRUGS	6,883.37

TOTAL NUMBER OF CLAIMS 2,736

OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,662.56	1,333.60
MED/SURG SUPPLY	45,155.18	1,844.96
LABORATORY-GENERAL	0.00	2,746.00
RADIOLOGY-DIAGNOSTIC	92,485.00	1,111.00
CT SCAN	140,755.00	46,850.00
PHYSICAL THERAPY	9,677.20	1,274.00
EKG/ECG	16,244.70	270.40
IV THERAPY	0.00	0.00
OPERATING ROOM	26,853.86	105.29
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,796.62	629.98
ANESTHESIA	2,990.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	134,615.95	6,476.96
RECOVERY ROOM	9,233.12	1,204.32
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,868.11	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	34,973.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	682.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,316.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,496.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,710.35	271.30
OTHER LAB SERVICES	43,210.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	228,923.51	54,853.68
MRI SERVICES	26,242.21	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	312.00	0.00
INJECTABLE DRUGS	10,077.30	372.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	105.00	9,416.62

TOTAL ANCILLARY	928,702.67	129,442.55
TOTAL ACCOMODATIONS	0.00	2,275.00
TOTAL CHARGES	928,702.67	131,717.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,404.20	ADJUSTMENTS	0.00
COVERED CHARGES	3,578.08	CONTRACTUAL ALLOW	867.41
NON-COVERED CHARGES	826.12	TOTAL MEDICAID LIAB	2,710.67
		LESS: COB	2,680.67
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	332.72-
		FEE SCHEDULE-LAB	330.60
		INJECTABLE DRUGS	2.12

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	278.80	40.00
MED/SURG SUPPLY	182.20	0.00
LABORATORY-GENERAL	0.00	41.60
RADIOLOGY-DIAGNOSTIC	151.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	135.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	950.56	266.92
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,877.20	471.36
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.12	6.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,578.08	826.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,578.08	826.12

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	92,482.39	ADJUSTMENTS	314.00
COVERED CHARGES	86,538.77	CONTRACTUAL ALLOW	57,027.28
NON-COVERED CHARGES	5,943.62	TOTAL MEDICAID LIAB	29,511.49
		LESS: COB	43.74
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	28,903.75

TOTAL NUMBER OF CLAIMS 594

OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,099.88	58.32
MED/SURG SUPPLY	2,719.04	19.76
LABORATORY-GENERAL	19,271.28	2,897.68
RADIOLOGY-DIAGNOSTIC	5,656.00	0.00
CT SCAN	6,360.00	1,760.00
PHYSICAL THERAPY	72.80	0.00
EKG/ECG	1,497.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	679.51	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,859.41	1,153.34
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	361.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	425.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,794.95	0.00
OTHER LAB SERVICES	288.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	62.40	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,391.90	54.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,538.77	5,943.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,538.77	5,943.62

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,999.34	ADJUSTMENTS	0.00
COVERED CHARGES	2,579.74	CONTRACTUAL ALLOW	2,518.50
NON-COVERED CHARGES	419.60	TOTAL MEDICAID LIAB	61.24
		LESS: COB	61.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	564.00	51.60
MED/SURG SUPPLY	9.10	0.00
LABORATORY-GENERAL	828.88	48.00
RADIOLOGY-DIAGNOSTIC	105.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,048.00	320.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.76	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,579.74	419.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,579.74	419.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
TITLE XVIII NO: HOSP11

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	90,311.79	ADJUSTMENTS	3,466.78
COVERED CHARGES	83,593.63	CONTRACTUAL ALLOW	41,992.27
NON-COVERED CHARGES	6,718.16	TOTAL MEDICAID LIAB	41,601.36
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	41,559.36

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON GA 31024-6054

PROVIDER NUMBER 000001537A
NUMBER OF BEDS 50
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP11

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,620.56	20.00
MED/SURG SUPPLY	38,622.43	0.00
LABORATORY-GENERAL	0.00	2,068.56
RADIOLOGY-DIAGNOSTIC	196.00	273.00
CT SCAN	8,400.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	535.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,876.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	853.32	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,505.84	36.92
RECOVERY ROOM	4,415.84	602.16
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	36.00	20.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	650.12	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,506.72	447.52
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	374.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	83,593.63	3,468.16
TOTAL ACCOMODATIONS	0.00	3,250.00
TOTAL CHARGES	83,593.63	6,718.16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
101 LAKE OCONEE PARKWAY	000001537A	50	SERVICE DATES 10/01/2005 THROUGH 09/30/2006
	TITLE XVIII NO: HOSP11		
EATONTON GA 31024-6054			

****** NO DATA ******

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	24,585,262.33	ADJUSTMENTS	230,173.91
COVERED CHARGES	23,180,147.09	CONTRACTUAL ALLOW	13,982,513.94
NON-COVERED CHARGES	1,405,115.24	TOTAL MEDICAID LIAB	9,197,633.15
		LESS: COB	11,657.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,185,975.57

TOTAL NUMBER OF ADMISSIONS 2,841

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,767	0	1,731,260.00	5,094.00
NURSERY CARE CHARGES	2,564	0	951,244.00	1,370,854.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,331	0	2,682,504.00	1,375,948.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	664	0	562,880.00	0.00
N I C U	1,463	0	4,520,670.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,127	0	5,083,550.00	0.00
TOTAL ACCOMODATIONS	9,458	0	7,766,054.00	1,375,948.00

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,278,243.70	0.00
MED/SURG SUPPLY	833,968.76	22,887.92
LABORATORY-GENERAL	3,102,668.05	0.00
RADIOLOGY-DIAGNOSTIC	245,842.00	0.00
CT SCAN	432,526.00	443.00
PHYSICAL THERAPY	62,723.00	0.00
EKG/ECG	44,483.00	0.00
IV THERAPY	4,278.00	0.00
OPERATING ROOM	2,161,039.00	0.00
LABOR/DELIVERY ROOM	1,849,601.00	0.00
RESPIRATORY SERVICES	587,920.00	0.00
ANESTHESIA	159,105.00	0.00
GI SERVICES	117,130.00	0.00
EMERGENCY ROOM	409,665.00	0.00
RECOVERY ROOM	121,563.00	0.00
LABORATORY PATHOLOGIC	190,279.00	0.00
RADIOLOGY THERAPEUTIC	316.00	0.00
OCCUPATIONAL THERAPY	23,377.00	0.00
SPEECH PATHOLOGY	15,648.00	0.00
RENAL DIALYSIS	51,240.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	368.54
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	193,879.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	139,004.00	861.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	121,020.00	0.00
AUDIOLOGY	98,230.00	94.00
CARDIOLOGY	188,581.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,315.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	52,592.92	0.00
OTHER LAB SERVICES	50,599.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	140,423.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	17.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	724,833.66	1,940.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,555.74

TOTAL ANCILLARY	15,414,093.09	29,167.24
TOTAL ACCOMODATIONS	7,766,054.00	1,375,948.00
TOTAL CHARGES	23,180,147.09	1,405,115.24

ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,197,851.10	ADJUSTMENTS	39,960.32
COVERED CHARGES	10,989,415.11	CONTRACTUAL ALLOW	6,763,105.58
NON-COVERED CHARGES	1,208,435.99	TOTAL MEDICAID LIAB	4,226,309.53
		LESS: COB	1,390.91
		LESS: COPAYMENT	11,742.00
		REIMBURSEMENT	4,213,176.62
		ALL OTHER	3,983,329.48
		FEE SCHEDULE-LAB	215,104.99
		INJECTABLE DRUGS	14,742.15

TOTAL NUMBER OF CLAIMS 11,414

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822,692.64	27,648.50
MED/SURG SUPPLY	334,522.43	8,934.74
LABORATORY-GENERAL	1,961.00	20,196.00
RADIOLOGY-DIAGNOSTIC	587,642.00	35,109.00
CT SCAN	1,021,857.00	54,093.00
PHYSICAL THERAPY	138,737.00	12,989.00
EKG/ECG	85,236.00	620.00
IV THERAPY	621.00	230.00
OPERATING ROOM	858,140.14	39,756.00
LABOR/DELIVERY ROOM	160,562.00	0.00
RESPIRATORY SERVICES	57,994.00	1,199.00
ANESTHESIA	427,117.47	1,464.00
GI SERVICES	72,380.00	21,244.00
EMERGENCY ROOM	2,164,947.00	119,806.00
RECOVERY ROOM	378,937.00	1,806.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	44,032.00	3,796.00
OCCUPATIONAL THERAPY	107,250.00	8,705.00
SPEECH PATHOLOGY	127,933.00	2,398.00
RENAL DIALYSIS	0.00	488.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,531.32	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	632,440.16	119,736.00
BLOOD	0.00	380.00
BLOOD STORAGE & PRO.	1,454.00	15,762.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	158,029.00	49,922.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	152,579.00	6,013.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,503.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	202,870.46	9,791.00
OTHER LAB SERVICES	59,107.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	780.00	540.00
OTHER THERAPEUTIC SERVI	0.00	81.00
SPECIAL CHARGES	2,065.00	0.00
FEE SCHEDULE LAB	1,885,206.98	440,455.06
MRI SERVICES	219,064.00	7,876.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	17.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	829.29	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	265,394.22	196,770.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	610.01

TOTAL ANCILLARY	10,989,415.11	1,208,435.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,989,415.11	1,208,435.99

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	24,812.43	ADJUSTMENTS	0.00
COVERED CHARGES	6,655.21	CONTRACTUAL ALLOW	5,698.31
NON-COVERED CHARGES	18,157.22	TOTAL MEDICAID LIAB	956.90
		LESS: COB	938.90
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	214.19-
		FEE SCHEDULE-LAB	214.19
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,901.15	1,222.85
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	60.00
RADIOLOGY-DIAGNOSTIC	165.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	780.00	834.00
OCCUPATIONAL THERAPY	978.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	489.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,748.00	2,620.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	594.06	13,419.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,655.21	18,157.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,655.21	18,157.22

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	828,726.01	ADJUSTMENTS	447.00
COVERED CHARGES	777,202.84	CONTRACTUAL ALLOW	707,125.82
NON-COVERED CHARGES	51,523.17	TOTAL MEDICAID LIAB	70,077.02
		LESS: COB	52.98
		LESS: COPAYMENT	1,299.00
		REIMBURSEMENT	68,725.04

TOTAL NUMBER OF CLAIMS 1,406

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,987.32	280.43
MED/SURG SUPPLY	4,043.67	450.66
LABORATORY-GENERAL	161,118.00	25,073.00
RADIOLOGY-DIAGNOSTIC	40,387.00	160.00
CT SCAN	63,054.00	0.00
PHYSICAL THERAPY	256.00	0.00
EKG/ECG	7,688.00	0.00
IV THERAPY	230.00	0.00
OPERATING ROOM	4,501.00	0.00
LABOR/DELIVERY ROOM	133.00	0.00
RESPIRATORY SERVICES	1,788.00	0.00
ANESTHESIA	2,479.00	0.00
GI SERVICES	2,061.00	0.00
EMERGENCY ROOM	412,779.00	19,936.00
RECOVERY ROOM	1,217.00	0.00
LABORATORY PATHOLOGIC	414.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,181.00	4,272.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,573.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,195.00	746.00
OTHER LAB SERVICES	5,197.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	314.61	94.86
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,606.24	510.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	777,202.84	51,523.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	777,202.84	51,523.17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,647.06	ADJUSTMENTS	0.00
COVERED CHARGES	2,686.40	CONTRACTUAL ALLOW	2,619.67
NON-COVERED CHARGES	5,960.66	TOTAL MEDICAID LIAB	66.73
		LESS: COB	63.73
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	294.09	310.88
MED/SURG SUPPLY	48.27	0.00
LABORATORY-GENERAL	445.00	854.00
RADIOLOGY-DIAGNOSTIC	120.00	165.00
CT SCAN	0.00	1,420.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	124.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,304.00	2,296.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	774.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	475.04	16.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,686.40	5,960.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,686.40	5,960.66

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	910,449.75	ADJUSTMENTS	3,947.19
COVERED CHARGES	869,550.04	CONTRACTUAL ALLOW	617,478.61
NON-COVERED CHARGES	40,899.71	TOTAL MEDICAID LIAB	252,071.43
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	251,900.43

TOTAL NUMBER OF CLAIMS 64

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	239,702.99	100.25
MED/SURG SUPPLY	71,315.59	0.00
LABORATORY-GENERAL	0.00	1,276.00
RADIOLOGY-DIAGNOSTIC	1,213.00	503.00
CT SCAN	19,367.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	868.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,770.00	2,025.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,029.00	0.00
ANESTHESIA	19,431.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,487.00	609.00
RECOVERY ROOM	11,037.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	23,969.00	1,765.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	31,640.00	0.00
OTHER IMAGING SERVICES	2,434.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	50.00	3,742.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,421.00	1,948.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,860.00	657.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,315.00	99.00
OTHER LAB SERVICES	793.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	174,940.94	24,207.47
MRI SERVICES	6,922.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	198,984.52	3,967.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	869,550.04	40,899.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	869,550.04	40,899.71

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	24,203,263.28	ADJUSTMENTS	481,308.65
COVERED CHARGES	22,549,394.03	CONTRACTUAL ALLOW	13,354,188.85
NON-COVERED CHARGES	1,653,869.25	TOTAL MEDICAID LIAB	9,195,205.18
		LESS: COB	16,572.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,178,632.90

TOTAL NUMBER OF ADMISSIONS 2,713

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,870	0	1,769,473.00	5,274.00
NURSERY CARE CHARGES	2,540	0	942,167.00	1,589,628.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,410	0	2,711,640.00	1,594,902.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	836	0	693,684.00	0.00
N I C U	1,310	0	4,047,900.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,146	0	4,741,584.00	0.00
TOTAL ACCOMODATIONS	9,556	0	7,453,224.00	1,594,902.00

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,554,502.81	0.00
MED/SURG SUPPLY	774,655.13	20,669.95
LABORATORY-GENERAL	3,157,881.31	0.00
RADIOLOGY-DIAGNOSTIC	259,520.43	0.00
CT SCAN	448,364.08	0.00
PHYSICAL THERAPY	73,213.34	0.00
EKG/ECG	45,459.00	0.00
IV THERAPY	38,377.00	0.00
OPERATING ROOM	1,848,756.78	0.00
LABOR/DELIVERY ROOM	1,663,677.00	0.00
RESPIRATORY SERVICES	513,906.00	0.00
ANESTHESIA	138,926.00	0.00
GI SERVICES	106,421.00	0.00
EMERGENCY ROOM	361,696.00	0.00
RECOVERY ROOM	124,938.00	0.00
LABORATORY PATHOLOGIC	190,936.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	27,414.00	0.00
SPEECH PATHOLOGY	17,153.00	72.00
RENAL DIALYSIS	66,368.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	183,319.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	185,125.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,709.29	0.00
AUDIOLOGY	45,496.00	27,542.00
CARDIOLOGY	214,845.05	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,974.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	169,433.22	0.00
OTHER LAB SERVICES	48,950.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	160,354.00	3,882.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,581,799.39	0.00
HOME HEALTH SERVICES	0.00	232.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,569.30

TOTAL ANCILLARY	15,096,170.03	58,967.25
TOTAL ACCOMODATIONS	7,453,224.00	1,594,902.00
TOTAL CHARGES	22,549,394.03	1,653,869.25

ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	155,736.33	ADJUSTMENTS	0.00
COVERED CHARGES	142,272.06	CONTRACTUAL ALLOW	69,023.10
NON-COVERED CHARGES	13,464.27	TOTAL MEDICAID LIAB	73,248.96
		LESS: COB	73,248.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	29	0	10,603.00	45.00
NURSERY CARE CHARGES	6	0	2,226.00	13,224.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	35	0	12,829.00	13,269.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	15	0	46,350.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	15	0	46,350.00	0.00
TOTAL ACCOMODATIONS	50	0	59,179.00	13,269.00

ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,627.70	0.00
MED/SURG SUPPLY	2,265.31	195.27
LABORATORY-GENERAL	19,593.00	0.00
RADIOLOGY-DIAGNOSTIC	1,318.75	0.00
CT SCAN	2,915.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	13,314.00	0.00
RESPIRATORY SERVICES	1,013.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,253.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	121.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	777.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	188.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,280.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,427.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	83,093.06	195.27
TOTAL ACCOMODATIONS	59,179.00	13,269.00
TOTAL CHARGES	142,272.06	13,464.27

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,696,031.70	ADJUSTMENTS	186,848.21
COVERED CHARGES	12,475,360.89	CONTRACTUAL ALLOW	8,468,236.56
NON-COVERED CHARGES	1,220,670.81	TOTAL MEDICAID LIAB	4,007,124.33
		LESS: COB	1,382.67
		LESS: COPAYMENT	7,146.00
		REIMBURSEMENT	3,998,595.66
		ALL OTHER	3,602,862.34
		FEE SCHEDULE-LAB	366,916.57
		INJECTABLE DRUGS	28,816.75

TOTAL NUMBER OF CLAIMS 12,118

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	597,459.71	50,068.41
MED/SURG SUPPLY	310,371.20	7,559.12
LABORATORY-GENERAL	9,498.00	23,048.00
RADIOLOGY-DIAGNOSTIC	656,524.58	17,980.00
CT SCAN	1,230,182.12	9,601.00
PHYSICAL THERAPY	162,288.28	466.00
EKG/ECG	88,904.00	0.00
IV THERAPY	61,234.00	736.00
OPERATING ROOM	684,107.27	18,468.06
LABOR/DELIVERY ROOM	135,565.00	532.00
RESPIRATORY SERVICES	55,812.86	8,901.00
ANESTHESIA	330,042.00	0.00
GI SERVICES	119,849.00	10,622.00
EMERGENCY ROOM	2,789,303.72	2,152.00
RECOVERY ROOM	299,467.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	59,877.85	1,614.00
OCCUPATIONAL THERAPY	125,609.13	4,818.00
SPEECH PATHOLOGY	137,353.00	136.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	17,830.00	0.00
OTHER IMAGING SERVICES	577,267.60	8,091.85
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,472.00	16,417.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	226,118.33	9,740.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	167,356.70	2,279.84
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,890.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	432,309.10	4,281.40
OTHER LAB SERVICES	54,448.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	770.00	0.00
OTHER THERAPEUTIC SERVI	0.00	462.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,789,587.25	691,984.68
MRI SERVICES	256,322.00	5,366.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	100.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	81,440.29	314,249.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11,080.12

TOTAL ANCILLARY	12,475,360.89	1,220,670.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,475,360.89	1,220,670.81

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	34,905.99	ADJUSTMENTS	0.00
COVERED CHARGES	30,685.50	CONTRACTUAL ALLOW	11,350.13
NON-COVERED CHARGES	4,220.49	TOTAL MEDICAID LIAB	19,335.37
		LESS: COB	19,326.37
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	464.14-
		FEE SCHEDULE-LAB	357.11
		INJECTABLE DRUGS	107.03

TOTAL NUMBER OF CLAIMS 40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	838.74	61.54
MED/SURG SUPPLY	371.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	877.00	0.00
CT SCAN	2,915.00	0.00
PHYSICAL THERAPY	3,445.00	0.00
EKG/ECG	141.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,182.00	0.00
LABOR/DELIVERY ROOM	480.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	541.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,279.00	261.00
RECOVERY ROOM	463.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,927.00	92.00
SPEECH PATHOLOGY	2,430.00	2,118.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,100.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	793.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	680.51	316.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,147.94	1,000.32
MRI SERVICES	1,728.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	345.55	247.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	124.00

TOTAL ANCILLARY	30,685.50	4,220.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,685.50	4,220.49

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	854,016.05	ADJUSTMENTS	3,013.49
COVERED CHARGES	821,913.68	CONTRACTUAL ALLOW	753,748.71
NON-COVERED CHARGES	32,102.37	TOTAL MEDICAID LIAB	68,164.97
		LESS: COB	0.00
		LESS: COPAYMENT	1,323.00
		REIMBURSEMENT	66,841.97

TOTAL NUMBER OF CLAIMS 1,356

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,227.34	401.50
MED/SURG SUPPLY	5,966.32	406.93
LABORATORY-GENERAL	156,688.00	17,889.00
RADIOLOGY-DIAGNOSTIC	38,216.00	526.00
CT SCAN	68,971.00	3,343.00
PHYSICAL THERAPY	292.00	0.00
EKG/ECG	8,349.00	0.00
IV THERAPY	2,530.00	0.00
OPERATING ROOM	4,220.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,705.00	0.00
ANESTHESIA	2,066.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	468,777.00	207.00
RECOVERY ROOM	2,412.00	0.00
LABORATORY PATHOLOGIC	228.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,793.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,992.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	872.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,338.35	0.00
OTHER LAB SERVICES	3,273.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	138.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,236.68	2,347.90
MRI SERVICES	1,880.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,880.99	6,843.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	821,913.68	32,102.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	821,913.68	32,102.37

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,675.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,994.11	CONTRACTUAL ALLOW	6,282.91
NON-COVERED CHARGES	681.14	TOTAL MEDICAID LIAB	711.20
		LESS: COB	696.20
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	337.36	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	1,632.00	350.00
RADIOLOGY-DIAGNOSTIC	453.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,398.00	299.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	34.91	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	138.84	32.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,994.11	681.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,994.11	681.14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	967,772.87	ADJUSTMENTS	11,871.57
COVERED CHARGES	906,225.18	CONTRACTUAL ALLOW	647,352.82
NON-COVERED CHARGES	61,547.69	TOTAL MEDICAID LIAB	258,872.36
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	258,707.36

TOTAL NUMBER OF CLAIMS 67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,001.60	896.03
MED/SURG SUPPLY	92,644.61	1,837.01
LABORATORY-GENERAL	304.00	323.00
RADIOLOGY-DIAGNOSTIC	11,570.22	1,914.00
CT SCAN	24,834.00	5,090.00
PHYSICAL THERAPY	47.00	0.00
EKG/ECG	1,043.00	0.00
IV THERAPY	920.00	230.00
OPERATING ROOM	77,046.00	1,350.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	920.00	301.00
ANESTHESIA	35,836.00	0.00
GI SERVICES	1,533.00	0.00
EMERGENCY ROOM	13,134.00	0.00
RECOVERY ROOM	30,453.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	18,588.09	1,298.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	37,348.00	0.00
OTHER IMAGING SERVICES	3,565.00	370.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	917.00	287.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,826.65	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,163.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,105.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,886.20	815.00
OTHER LAB SERVICES	793.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	359,180.28	23,257.56
MRI SERVICES	14,333.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,233.03	23,579.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	906,225.18	61,547.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	906,225.18	61,547.69

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,181,880.49	ADJUSTMENTS	1,129,013.68
COVERED CHARGES	21,580,830.44	CONTRACTUAL ALLOW	13,417,009.23
NON-COVERED CHARGES	1,601,050.05	TOTAL MEDICAID LIAB	8,163,821.21
		LESS: COB	28,183.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,135,637.89

TOTAL NUMBER OF ADMISSIONS 2,436

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,207	0	1,537,119.80	24,652.63
NURSERY CARE CHARGES	2,242	0	831,782.00	1,271,694.80
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	6,449	2	2,368,901.80	1,296,347.43
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	723	0	631,303.12	0.00
N I C U	1,007	0	3,380,398.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,730	0	4,011,701.12	0.00
TOTAL ACCOMODATIONS	8,179	2	6,380,602.92	1,296,347.43

INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,675,810.59	0.00
MED/SURG SUPPLY	715,811.37	12,072.16
LABORATORY-GENERAL	3,214,069.38	0.00
RADIOLOGY-DIAGNOSTIC	267,218.72	0.00
CT SCAN	499,800.84	0.00
PHYSICAL THERAPY	62,919.46	0.00
EKG/ECG	47,545.80	0.00
IV THERAPY	185,184.09	0.00
OPERATING ROOM	2,155,933.47	0.00
LABOR/DELIVERY ROOM	1,727,787.00	0.00
RESPIRATORY SERVICES	556,870.66	162.00
ANESTHESIA	119,813.10	0.00
GI SERVICES	77,113.50	0.00
EMERGENCY ROOM	384,402.91	0.00
RECOVERY ROOM	93,291.30	0.00
LABORATORY PATHOLOGIC	210,340.09	0.00
RADIOLOGY THERAPEUTIC	1,652.19	0.00
OCCUPATIONAL THERAPY	24,471.75	0.00
SPEECH PATHOLOGY	15,002.70	24.00
RENAL DIALYSIS	72,029.75	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	183,975.88	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	239,347.75	50,468.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	108,205.83	0.00
AUDIOLOGY	94.00	84,012.50
CARDIOLOGY	280,228.29	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,518.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	391,788.27	0.00
OTHER LAB SERVICES	65,677.78	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	136,583.65
SPECIAL CHARGES	510.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	165,084.38	10,352.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	134.40
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,641,728.47	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10,893.61

TOTAL ANCILLARY	15,200,227.52	304,702.62
TOTAL ACCOMODATIONS	6,380,602.92	1,296,347.43
TOTAL CHARGES	21,580,830.44	1,601,050.05

ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	486,032.90	ADJUSTMENTS	0.00
COVERED CHARGES	395,582.46	CONTRACTUAL ALLOW	187,112.51
NON-COVERED CHARGES	90,450.44	TOTAL MEDICAID LIAB	208,469.95
		LESS: COB	208,469.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17	0	6,151.00	24.50
NURSERY CARE CHARGES	42	0	15,582.00	88,249.60
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	59	0	21,733.00	88,274.10
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	65	0	228,674.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	65	0	228,674.00	0.00
TOTAL ACCOMODATIONS	124	0	250,407.00	88,274.10

ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,094.75	0.00
MED/SURG SUPPLY	6,091.32	0.00
LABORATORY-GENERAL	43,495.90	0.00
RADIOLOGY-DIAGNOSTIC	2,040.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	366.70	0.00
OPERATING ROOM	24,919.30	0.00
LABOR/DELIVERY ROOM	2,471.20	0.00
RESPIRATORY SERVICES	10,510.98	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	1,143.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,855.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,161.00	1,746.36
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	282.00
CARDIOLOGY	846.48	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,636.10	0.00
OTHER LAB SERVICES	117.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	147.98
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,425.43	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	145,175.46	2,176.34
TOTAL ACCOMODATIONS	250,407.00	88,274.10
TOTAL CHARGES	395,582.46	90,450.44

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	12,708,443.00	ADJUSTMENTS	104,993.36
COVERED CHARGES	11,107,039.27	CONTRACTUAL ALLOW	8,446,130.84
NON-COVERED CHARGES	1,601,403.73	TOTAL MEDICAID LIAB	2,660,908.43
		LESS: COB	4,715.28
		LESS: COPAYMENT	7,803.00
		REIMBURSEMENT	2,648,390.15
		ALL OTHER	2,337,297.09
		FEE SCHEDULE-LAB	280,073.62
		INJECTABLE DRUGS	31,019.44

TOTAL NUMBER OF CLAIMS 9,293

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296,997.18	9,806.52
MED/SURG SUPPLY	306,297.89	17,006.64
LABORATORY-GENERAL	608.00	8,891.40
RADIOLOGY-DIAGNOSTIC	593,158.35	32,494.20
CT SCAN	874,331.22	339,666.55
PHYSICAL THERAPY	133,582.65	3,016.50
EKG/ECG	80,858.80	0.00
IV THERAPY	106,227.71	54,152.90
OPERATING ROOM	724,779.68	41,289.86
LABOR/DELIVERY ROOM	105,374.60	854.00
RESPIRATORY SERVICES	55,859.01	14,867.30
ANESTHESIA	359,453.90	445.00
GI SERVICES	116,170.40	6,579.95
EMERGENCY ROOM	2,571,054.02	56,981.99
RECOVERY ROOM	317,381.30	2,908.50
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	44,518.98	25,293.33
OCCUPATIONAL THERAPY	129,383.41	4,613.00
SPEECH PATHOLOGY	149,135.90	136.00
RENAL DIALYSIS	0.00	884.75
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	17,830.00	0.00
OTHER IMAGING SERVICES	495,221.45	20,077.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,120.30	31,649.68
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	155,938.33	0.00
AUDIOLOGY	0.00	94.00
CARDIOLOGY	107,663.17	13,041.13
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,511.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	371,046.96	200,633.03
OTHER LAB SERVICES	107,793.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,111.10	1,480.50
OTHER THERAPEUTIC SERVI	0.00	86,483.32
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,653,195.67	462,875.39
MRI SERVICES	106,199.43	11,530.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	3,228.37	1,421.64
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	19.58	0.00
INJECTABLE DRUGS	110,987.41	139,593.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	12,634.48

TOTAL ANCILLARY	11,107,039.27	1,601,403.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,107,039.27	1,601,403.73

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	72,590.01	ADJUSTMENTS	0.00
COVERED CHARGES	58,837.57	CONTRACTUAL ALLOW	26,341.00
NON-COVERED CHARGES	13,752.44	TOTAL MEDICAID LIAB	32,496.57
		LESS: COB	32,481.57
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,195.05-
		FEE SCHEDULE-LAB	1,045.86
		INJECTABLE DRUGS	149.19

TOTAL NUMBER OF CLAIMS 63

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,452.18	255.45
MED/SURG SUPPLY	1,627.37	92.80
LABORATORY-GENERAL	0.00	916.00
RADIOLOGY-DIAGNOSTIC	1,039.20	179.00
CT SCAN	261.00	1,460.00
PHYSICAL THERAPY	2,816.80	0.00
EKG/ECG	0.00	0.00
IV THERAPY	713.10	0.00
OPERATING ROOM	2,194.50	1,811.50
LABOR/DELIVERY ROOM	3,107.80	0.00
RESPIRATORY SERVICES	134.00	45.88
ANESTHESIA	1,973.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,342.60	104.13
RECOVERY ROOM	1,795.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,939.40	616.00
SPEECH PATHOLOGY	10,445.00	112.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,994.20	657.60
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	432.19	1,045.02
OTHER LAB SERVICES	911.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	267.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,090.97	3,917.48
MRI SERVICES	0.00	1,940.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	566.86	331.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	58,837.57	13,752.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,837.57	13,752.44

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	847,172.08	ADJUSTMENTS	1,374.38
COVERED CHARGES	779,739.94	CONTRACTUAL ALLOW	722,859.00
NON-COVERED CHARGES	67,432.14	TOTAL MEDICAID LIAB	56,880.94
		LESS: COB	5.00
		LESS: COPAYMENT	1,185.00
		REIMBURSEMENT	55,690.94

TOTAL NUMBER OF CLAIMS 1,119

OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,837.75	0.00
MED/SURG SUPPLY	3,869.76	107.59
LABORATORY-GENERAL	134,966.40	16,289.40
RADIOLOGY-DIAGNOSTIC	40,919.85	0.00
CT SCAN	38,267.80	26,659.10
PHYSICAL THERAPY	327.40	0.00
EKG/ECG	5,463.00	0.00
IV THERAPY	7,056.00	3,682.50
OPERATING ROOM	1,334.80	122.25
LABOR/DELIVERY ROOM	532.00	0.00
RESPIRATORY SERVICES	4,129.53	0.00
ANESTHESIA	541.00	0.00
GI SERVICES	1,990.00	0.00
EMERGENCY ROOM	474,680.52	9,190.64
RECOVERY ROOM	606.00	0.00
LABORATORY PATHOLOGIC	363.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	240.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,715.50	370.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	122.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,366.49	1,225.35
OTHER LAB SERVICES	4,850.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	5,075.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,825.57	690.79
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,097.42	3,656.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	779,739.94	67,432.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	779,739.94	67,432.14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	25,106.43	ADJUSTMENTS	0.00
COVERED CHARGES	21,835.17	CONTRACTUAL ALLOW	20,096.17
NON-COVERED CHARGES	3,271.26	TOTAL MEDICAID LIAB	1,739.00
		LESS: COB	1,706.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	448.90	0.00
MED/SURG SUPPLY	50.19	0.00
LABORATORY-GENERAL	5,380.00	874.10
RADIOLOGY-DIAGNOSTIC	659.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,629.41	2,037.86
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,186.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	368.87	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	112.80	359.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,835.17	3,271.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,835.17	3,271.26

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	903,592.12	ADJUSTMENTS	6,742.14
COVERED CHARGES	737,220.87	CONTRACTUAL ALLOW	572,992.62
NON-COVERED CHARGES	166,371.25	TOTAL MEDICAID LIAB	164,228.25
		LESS: COB	0.00
		LESS: COPAYMENT	450.00
		REIMBURSEMENT	163,778.25

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP15

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,775.85	267.33
MED/SURG SUPPLY	25,420.27	3,084.83
LABORATORY-GENERAL	0.00	197.50
RADIOLOGY-DIAGNOSTIC	36,048.48	15,342.68
CT SCAN	23,718.40	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,374.60	0.00
IV THERAPY	4,832.80	1,852.40
OPERATING ROOM	30,308.81	1,343.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	102.60	0.00
ANESTHESIA	7,861.80	0.00
GI SERVICES	1,332.50	0.00
EMERGENCY ROOM	5,868.80	0.00
RECOVERY ROOM	6,984.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	26,496.62	15,322.36
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	37,888.80	0.00
OTHER IMAGING SERVICES	3,005.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	8,944.52
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,393.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,256.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,058.48	14,482.90
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,361.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	447,603.02	62,090.08
MRI SERVICES	7,668.00	2,800.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,222.34	39,281.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	737,220.87	166,371.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	737,220.87	166,371.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS GA 30012-3877

PROVIDER NUMBER 000001603A
NUMBER OF BEDS 107
TITLE XVIII NO: HOSP15

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,370,807.86	ADJUSTMENTS	866,735.15
COVERED CHARGES	2,370,360.86	CONTRACTUAL ALLOW	362,751.91
NON-COVERED CHARGES	447.00	TOTAL MEDICAID LIAB	2,007,608.95
		LESS: COB	27,840.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,979,768.25

TOTAL NUMBER OF ADMISSIONS 93

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,986	0	1,286,966.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,986	0	1,286,966.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,986	0	1,286,966.00	0.00

INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,394.12	0.00
MED/SURG SUPPLY	22,230.28	0.00
LABORATORY-GENERAL	89,095.40	364.00
RADIOLOGY-DIAGNOSTIC	24,786.75	0.00
CT SCAN	13,616.20	0.00
PHYSICAL THERAPY	213,857.00	0.00
EKG/ECG	7,424.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,728.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,534.00	0.00
ANESTHESIA	278.00	0.00
GI SERVICES	729.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,200.00	0.00
LABORATORY PATHOLOGIC	117.00	0.00
RADIOLOGY THERAPEUTIC	7,238.00	0.00
OCCUPATIONAL THERAPY	254,888.00	0.00
SPEECH PATHOLOGY	98,962.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	83.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,348.65	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	9,469.00	0.00
CARDIOLOGY	3,124.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,100.65	0.00
OTHER LAB SERVICES	2,970.00	0.00
RECREATIONAL THERAPY	15,649.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,655.01	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,083,394.86	447.00
TOTAL ACCOMODATIONS	1,286,966.00	0.00
TOTAL CHARGES	2,370,360.86	447.00

ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	296,567.50	ADJUSTMENTS	2,075.33
COVERED CHARGES	296,229.50	CONTRACTUAL ALLOW	84,032.57
NON-COVERED CHARGES	338.00	TOTAL MEDICAID LIAB	212,196.93
		LESS: COB	9,922.66
		LESS: COPAYMENT	2,733.00
		REIMBURSEMENT	199,541.27
		ALL OTHER	199,495.18
		FEE SCHEDULE-LAB	46.09
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,989

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	970.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	172,284.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	65,859.00	0.00
SPEECH PATHOLOGY	55,543.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,382.00	335.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	191.50	3.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	296,229.50	338.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	296,229.50	338.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,711.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,536.00	CONTRACTUAL ALLOW	3,290.76
NON-COVERED CHARGES	175.00	TOTAL MEDICAID LIAB	9,245.24
		LESS: COB	9,194.24
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	5,095.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,543.00	0.00
SPEECH PATHOLOGY	2,898.00	175.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,536.00	175.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,536.00	175.00

OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,208,228.41	ADJUSTMENTS	700,929.79
COVERED CHARGES	2,542,767.38	CONTRACTUAL ALLOW	437,739.44
NON-COVERED CHARGES	665,461.03	TOTAL MEDICAID LIAB	2,105,027.94
		LESS: COB	12,912.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,092,114.96

TOTAL NUMBER OF ADMISSIONS 106

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,870	0	1,236,970.00	563,397.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,870	0	1,236,970.00	563,397.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	131	0.00	100,705.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	131	0.00	100,705.00
TOTAL ACCOMODATIONS	2,870	131	1,236,970.00	664,102.00

INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298,427.29	0.00
MED/SURG SUPPLY	36,548.18	0.00
LABORATORY-GENERAL	105,633.15	0.00
RADIOLOGY-DIAGNOSTIC	28,792.44	0.00
CT SCAN	18,986.79	0.00
PHYSICAL THERAPY	266,954.00	0.00
EKG/ECG	9,664.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,722.00	264.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,050.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,284.00	0.00
LABORATORY PATHOLOGIC	1,056.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	321,902.00	0.00
SPEECH PATHOLOGY	142,165.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,023.76	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	780.03
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	371.00	0.00
AUDIOLOGY	14,917.00	0.00
CARDIOLOGY	2,585.78	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,033.20	0.00
OTHER LAB SERVICES	3,240.00	0.00
RECREATIONAL THERAPY	9,224.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,216.93	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	315.00

TOTAL ANCILLARY	1,305,797.38	1,359.03
TOTAL ACCOMODATIONS	1,236,970.00	664,102.00
TOTAL CHARGES	2,542,767.38	665,461.03

ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	254,142.00	ADJUSTMENTS	3,491.98
COVERED CHARGES	253,778.00	CONTRACTUAL ALLOW	141,535.12
NON-COVERED CHARGES	364.00	TOTAL MEDICAID LIAB	112,242.88
		LESS: COB	2,110.52
		LESS: COPAYMENT	2,961.00
		REIMBURSEMENT	107,171.36
		ALL OTHER	106,642.17
		FEE SCHEDULE-LAB	529.19
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,665

OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	416.00	0.00
MED/SURG SUPPLY	278.00	0.00
LABORATORY-GENERAL	0.00	73.00
RADIOLOGY-DIAGNOSTIC	1,414.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	171,121.00	0.00
EKG/ECG	132.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	568.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	48,019.00	0.00
SPEECH PATHOLOGY	26,425.00	110.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,247.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,158.00	181.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	253,778.00	364.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	253,778.00	364.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	14,836.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,606.00	CONTRACTUAL ALLOW	3,624.93
NON-COVERED CHARGES	230.00	TOTAL MEDICAID LIAB	10,981.07
		LESS: COB	10,951.07
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 79

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0178GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	9,131.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,469.00	92.00
SPEECH PATHOLOGY	2,006.00	138.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,606.00	230.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,606.00	230.00

OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS
6135 ROOSEVELT HWY
WARM SPRINGS GA 31830-0268

PROVIDER NUMBER 000000778A
NUMBER OF BEDS 102
TITLE XVIII NO: HPH0178GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,221,980.29	ADJUSTMENTS	226,599.80
COVERED CHARGES	18,790,918.69	CONTRACTUAL ALLOW	10,082,261.94
NON-COVERED CHARGES	431,061.60	TOTAL MEDICAID LIAB	8,708,656.75
		LESS: COB	85,391.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,623,264.80

TOTAL NUMBER OF ADMISSIONS 2,167

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,060	0	2,319,340.00	267,675.00
NURSERY CARE CHARGES	1,152	0	392,630.00	19,370.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	6,212	3	2,711,970.00	287,045.00
SPECIAL CARE SERVICES				
C C U	367	0	393,350.00	0.00
I C U	407	0	444,100.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	82	0.00	42,640.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	774	82	837,450.00	42,640.00
TOTAL ACCOMODATIONS	6,986	85	3,549,420.00	329,685.00

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,077,284.22	0.00
MED/SURG SUPPLY	1,871,417.97	1,956.90
LABORATORY-GENERAL	1,278,478.48	1,440.00
RADIOLOGY-DIAGNOSTIC	297,754.10	0.00
CT SCAN	472,055.50	2,465.70
PHYSICAL THERAPY	113,321.00	0.00
EKG/ECG	100,920.70	0.00
IV THERAPY	70,810.00	0.00
OPERATING ROOM	2,595,805.22	0.00
LABOR/DELIVERY ROOM	503,683.00	0.00
RESPIRATORY SERVICES	805,692.52	0.00
ANESTHESIA	19,450.00	0.00
GI SERVICES	209,789.00	0.00
EMERGENCY ROOM	600,818.42	0.00
RECOVERY ROOM	173,358.10	0.00
LABORATORY PATHOLOGIC	35,633.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	21,325.00	0.00
SPEECH PATHOLOGY	18,690.00	0.00
RENAL DIALYSIS	168,210.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	12,960.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	135,232.30	2,680.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	226,756.20	63,660.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	235,012.65	0.00
AUDIOLOGY	56,500.00	0.00
CARDIOLOGY	579,441.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	34,918.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	352,725.80	0.00
OTHER LAB SERVICES	93,922.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	244.60	192.00
OTHER THERAPEUTIC SERVI	0.00	8,785.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	85,780.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,467.80	0.00
HOME HEALTH SERVICES	0.00	6,384.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	853.00

TOTAL ANCILLARY	15,241,498.69	101,376.60
TOTAL ACCOMODATIONS	3,549,420.00	329,685.00
TOTAL CHARGES	18,790,918.69	431,061.60

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	381,500.35	ADJUSTMENTS	0.00
COVERED CHARGES	374,385.35	CONTRACTUAL ALLOW	108,242.68
NON-COVERED CHARGES	7,115.00	TOTAL MEDICAID LIAB	266,142.67
		LESS: COB	266,142.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	103	0	47,415.00	5,855.00
NURSERY CARE CHARGES	22	0	7,370.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	125	0	54,785.00	5,855.00
SPECIAL CARE SERVICES				
C C U	5	0	5,500.00	0.00
I C U	2	0	2,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	7,700.00	0.00
TOTAL ACCOMODATIONS	132	0	62,485.00	5,855.00

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,985.80	0.00
MED/SURG SUPPLY	24,556.75	0.00
LABORATORY-GENERAL	23,819.70	0.00
RADIOLOGY-DIAGNOSTIC	4,285.60	0.00
CT SCAN	8,180.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,729.75	0.00
IV THERAPY	270.00	0.00
OPERATING ROOM	106,492.41	0.00
LABOR/DELIVERY ROOM	23,650.00	0.00
RESPIRATORY SERVICES	11,423.59	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,240.00	0.00
RECOVERY ROOM	8,343.60	0.00
LABORATORY PATHOLOGIC	942.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	7,000.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,117.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,526.00	1,200.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,743.60	0.00
AUDIOLOGY	600.00	0.00
CARDIOLOGY	14,172.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,968.00	0.00
OTHER LAB SERVICES	716.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	60.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,137.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	311,900.35	1,260.00
TOTAL ACCOMODATIONS	62,485.00	5,855.00
TOTAL CHARGES	374,385.35	7,115.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	16,156,157.32	ADJUSTMENTS	97,497.70
COVERED CHARGES	15,335,580.90	CONTRACTUAL ALLOW	9,184,499.03
NON-COVERED CHARGES	820,576.42	TOTAL MEDICAID LIAB	6,151,081.87
		LESS: COB	5,833.34
		LESS: COPAYMENT	19,959.00
		REIMBURSEMENT	6,125,289.53
		ALL OTHER	5,735,461.70
		FEE SCHEDULE-LAB	366,021.93
		INJECTABLE DRUGS	23,805.90

TOTAL NUMBER OF CLAIMS 17,484

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	938,923.17	50,361.27
MED/SURG SUPPLY	683,915.60	28,236.45
LABORATORY-GENERAL	630.00	82,557.15
RADIOLOGY-DIAGNOSTIC	704,867.70	40,248.80
CT SCAN	1,148,691.90	18,792.80
PHYSICAL THERAPY	262,440.00	15,855.00
EKG/ECG	179,836.35	3,349.00
IV THERAPY	130,915.00	4,985.00
OPERATING ROOM	2,807,481.27	70,057.25
LABOR/DELIVERY ROOM	3,050.00	0.00
RESPIRATORY SERVICES	206,637.76	2,489.80
ANESTHESIA	12,000.00	0.00
GI SERVICES	447,679.00	0.00
EMERGENCY ROOM	2,683,192.26	6,370.00
RECOVERY ROOM	473,628.40	1,025.90
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	18,975.00	1,860.00
SPEECH PATHOLOGY	33,850.00	5,520.00
RENAL DIALYSIS	0.00	1,750.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	189,810.00	4,330.00
PSYCHIATRIC SERVICES	0.00	145.00
LITHOTRIPSY	53,600.00	0.00
OTHER IMAGING SERVICES	709,619.95	30,189.95
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	49,738.00	17,720.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	406,098.85	27,596.70
AUDIOLOGY	1,305.00	0.00
CARDIOLOGY	473,761.74	45,458.30
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,797.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	630,816.60	20,151.50
OTHER LAB SERVICES	285,015.10	580.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	916.70	926.90
OTHER THERAPEUTIC SERVI	0.00	33,785.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,267,531.07	169,878.90
MRI SERVICES	324,820.00	5,360.00
PROFESSIONAL FEES	0.00	424.10
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	94.50	850.50
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	174,942.23	129,721.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	15,335,580.90	820,576.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,335,580.90	820,576.42

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	64,274.76	ADJUSTMENTS	0.00
COVERED CHARGES	56,346.16	CONTRACTUAL ALLOW	26,447.35
NON-COVERED CHARGES	7,928.60	TOTAL MEDICAID LIAB	29,898.81
		LESS: COB	29,835.81
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,141.60-
		FEE SCHEDULE-LAB	1,141.60
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 53

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,622.95	0.00
MED/SURG SUPPLY	2,962.56	0.00
LABORATORY-GENERAL	0.00	222.00
RADIOLOGY-DIAGNOSTIC	1,374.60	0.00
CT SCAN	1,080.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,183.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,825.50	5,798.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	143.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,961.00	0.00
EMERGENCY ROOM	7,320.00	0.00
RECOVERY ROOM	2,617.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	800.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,344.05	716.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,371.80	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,949.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,959.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,356.00	646.00
MRI SERVICES	5,460.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.50	546.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	56,346.16	7,928.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,346.16	7,928.60

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	686,567.81	ADJUSTMENTS	841.00
COVERED CHARGES	674,608.61	CONTRACTUAL ALLOW	595,658.61
NON-COVERED CHARGES	11,959.20	TOTAL MEDICAID LIAB	78,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,563.00
		REIMBURSEMENT	77,387.00

TOTAL NUMBER OF CLAIMS 1,579

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,227.81	374.75
MED/SURG SUPPLY	21,443.45	2,715.70
LABORATORY-GENERAL	50,089.07	5,419.00
RADIOLOGY-DIAGNOSTIC	41,606.60	631.90
CT SCAN	21,374.20	0.00
PHYSICAL THERAPY	2,175.00	0.00
EKG/ECG	2,442.00	0.00
IV THERAPY	3,745.00	0.00
OPERATING ROOM	16,401.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,187.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	429,689.68	0.00
RECOVERY ROOM	2,251.80	0.00
LABORATORY PATHOLOGIC	214.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	250.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	320.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,235.00	318.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,136.10	1,136.10
AUDIOLOGY	435.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	392.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,650.00	0.00
OTHER LAB SERVICES	5,015.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,800.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,527.25	1,263.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	100.00

TOTAL ANCILLARY	674,608.61	11,959.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	674,608.61	11,959.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,093.80	ADJUSTMENTS	0.00
COVERED CHARGES	3,390.80	CONTRACTUAL ALLOW	2,948.07
NON-COVERED CHARGES	1,703.00	TOTAL MEDICAID LIAB	442.73
		LESS: COB	430.73
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	721.45	0.00
MED/SURG SUPPLY	302.10	0.00
LABORATORY-GENERAL	357.00	8.00
RADIOLOGY-DIAGNOSTIC	85.30	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	101.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	143.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,680.00	1,695.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,390.80	1,703.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,390.80	1,703.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE

WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,092,405.37	ADJUSTMENTS	8,186.87
COVERED CHARGES	1,061,059.63	CONTRACTUAL ALLOW	720,921.61
NON-COVERED CHARGES	31,345.74	TOTAL MEDICAID LIAB	340,138.02
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	340,000.02

TOTAL NUMBER OF CLAIMS 83

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,505.92	4,248.94
MED/SURG SUPPLY	135,131.45	214.50
LABORATORY-GENERAL	0.00	1,216.00
RADIOLOGY-DIAGNOSTIC	14,019.10	4,964.60
CT SCAN	17,695.10	0.00
PHYSICAL THERAPY	2,085.00	0.00
EKG/ECG	7,892.60	0.00
IV THERAPY	11,575.00	0.00
OPERATING ROOM	455,108.42	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,647.00	0.00
ANESTHESIA	2,750.00	0.00
GI SERVICES	9,393.00	0.00
EMERGENCY ROOM	30,380.00	0.00
RECOVERY ROOM	32,289.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	3,500.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,895.80	1,125.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	600.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,699.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	84,717.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,178.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	76,757.00	697.00
OTHER LAB SERVICES	10,644.85	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	34,091.70	4,886.00
MRI SERVICES	9,580.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,422.94	10,461.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	32.00

TOTAL ANCILLARY	1,061,059.63	31,345.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,061,059.63	31,345.74

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	17,172.13	ADJUSTMENTS	0.00
COVERED CHARGES	17,108.63	CONTRACTUAL ALLOW	5,493.59
NON-COVERED CHARGES	63.50	TOTAL MEDICAID LIAB	11,615.04
		LESS: COB	11,615.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,834.70	0.00
MED/SURG SUPPLY	1,064.13	0.00
LABORATORY-GENERAL	0.00	16.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	2,280.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	705.00	0.00
OPERATING ROOM	6,079.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,045.00	0.00
RECOVERY ROOM	333.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,594.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	173.00	32.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	15.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,108.63	63.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,108.63	63.50

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,767,114.75	ADJUSTMENTS	416,696.42
COVERED CHARGES	19,474,228.56	CONTRACTUAL ALLOW	10,931,389.86
NON-COVERED CHARGES	292,886.19	TOTAL MEDICAID LIAB	8,542,838.70
		LESS: COB	112,582.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,430,255.77

TOTAL NUMBER OF ADMISSIONS 2,155

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,516	0	2,235,420.00	159,904.99
NURSERY CARE CHARGES	1,322	0	469,895.00	14,620.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	5,838	1	2,705,315.00	174,524.99
SPECIAL CARE SERVICES				
C C U	496	0	544,975.00	0.00
I C U	475	0	525,975.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	2	0.00	1,080.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	971	2	1,070,950.00	1,080.00
TOTAL ACCOMODATIONS	6,809	3	3,776,265.00	175,604.99

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,125,960.86	0.00
MED/SURG SUPPLY	1,912,504.15	2,805.10
LABORATORY-GENERAL	1,397,532.55	753.00
RADIOLOGY-DIAGNOSTIC	258,655.75	0.00
CT SCAN	558,912.10	0.00
PHYSICAL THERAPY	89,473.25	0.00
EKG/ECG	94,363.95	0.00
IV THERAPY	102,796.00	0.00
OPERATING ROOM	2,630,545.65	0.00
LABOR/DELIVERY ROOM	548,756.00	0.00
RESPIRATORY SERVICES	980,520.00	0.00
ANESTHESIA	11,730.00	0.00
GI SERVICES	242,583.65	0.00
EMERGENCY ROOM	607,190.65	0.00
RECOVERY ROOM	182,495.75	0.00
LABORATORY PATHOLOGIC	34,480.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,718.00	0.00
SPEECH PATHOLOGY	5,054.40	0.00
RENAL DIALYSIS	254,800.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	9,993.20
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	106,452.55	2,787.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	270,796.95	88,830.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	162,740.05	0.00
AUDIOLOGY	61,600.00	0.00
CARDIOLOGY	440,324.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	23,094.95	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	366,413.30	171.60
OTHER LAB SERVICES	93,215.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	100.00	0.00
OTHER THERAPEUTIC SERVI	0.00	7,358.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	129,637.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,515.15	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,583.10

TOTAL ANCILLARY	15,697,963.56	117,281.20
TOTAL ACCOMODATIONS	3,776,265.00	175,604.99
TOTAL CHARGES	19,474,228.56	292,886.19

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	612,808.83	ADJUSTMENTS	0.00
COVERED CHARGES	601,132.08	CONTRACTUAL ALLOW	164,710.23
NON-COVERED CHARGES	11,676.75	TOTAL MEDICAID LIAB	436,421.85
		LESS: COB	436,421.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 61

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	182	0	90,090.00	7,825.00
NURSERY CARE CHARGES	25	0	9,040.00	710.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	207	0	99,130.00	8,535.00
SPECIAL CARE SERVICES				
C C U	1	0	1,150.00	0.00
I C U	12	0	13,800.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	13	0	14,950.00	0.00
TOTAL ACCOMODATIONS	220	0	114,080.00	8,535.00

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,025.64	0.00
MED/SURG SUPPLY	68,511.32	72.70
LABORATORY-GENERAL	35,450.65	31.20
RADIOLOGY-DIAGNOSTIC	6,113.95	0.00
CT SCAN	19,756.65	0.00
PHYSICAL THERAPY	2,028.00	0.00
EKG/ECG	1,620.50	0.00
IV THERAPY	2,010.00	0.00
OPERATING ROOM	121,686.75	0.00
LABOR/DELIVERY ROOM	22,620.00	0.00
RESPIRATORY SERVICES	14,643.45	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	9,771.90	0.00
EMERGENCY ROOM	12,534.70	0.00
RECOVERY ROOM	9,282.60	0.00
LABORATORY PATHOLOGIC	1,618.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	119.60	0.00
SPEECH PATHOLOGY	509.60	0.00
RENAL DIALYSIS	9,100.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,095.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,495.90	1,575.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,381.40	0.00
AUDIOLOGY	700.00	0.00
CARDIOLOGY	4,805.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	408.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,488.70	0.00
OTHER LAB SERVICES	3,360.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,488.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,140.65
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,424.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	171.40

TOTAL ANCILLARY	487,052.08	3,141.75
TOTAL ACCOMODATIONS	114,080.00	8,535.00
TOTAL CHARGES	601,132.08	11,676.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	16,234,131.72	ADJUSTMENTS	556,414.00
COVERED CHARGES	15,256,072.58	CONTRACTUAL ALLOW	10,231,275.29
NON-COVERED CHARGES	978,059.14	TOTAL MEDICAID LIAB	5,024,797.29
		LESS: COB	3,346.14
		LESS: COPAYMENT	13,752.00
		REIMBURSEMENT	5,007,699.15
		ALL OTHER	4,614,114.11
		FEE SCHEDULE-LAB	393,588.42
		INJECTABLE DRUGS	3.38-

TOTAL NUMBER OF CLAIMS 16,311

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	905,037.65	21,342.92
MED/SURG SUPPLY	695,407.76	22,314.62
LABORATORY-GENERAL	1,747.20	33,268.55
RADIOLOGY-DIAGNOSTIC	691,405.20	41,337.75
CT SCAN	1,122,158.95	70,345.45
PHYSICAL THERAPY	199,108.00	343.20
EKG/ECG	174,920.25	636.00
IV THERAPY	233,345.00	0.00
OPERATING ROOM	2,806,470.02	114,059.57
LABOR/DELIVERY ROOM	1,508.00	0.00
RESPIRATORY SERVICES	160,865.00	0.00
ANESTHESIA	12,400.00	0.00
GI SERVICES	373,704.15	0.00
EMERGENCY ROOM	2,736,270.05	2,287.00
RECOVERY ROOM	452,310.70	390.45
LABORATORY PATHOLOGIC	0.00	208.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	36,550.80	0.00
SPEECH PATHOLOGY	23,316.80	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	126,651.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	20,904.00	0.00
OTHER IMAGING SERVICES	695,469.75	29,845.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	36,811.05	15,591.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	395,097.65	8,225.70
AUDIOLOGY	552.40	0.00
CARDIOLOGY	641,359.70	30,165.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,578.45	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	692,600.25	2,039.60
OTHER LAB SERVICES	263,794.30	1,333.35
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	811.15	899.00
OTHER THERAPEUTIC SERVI	150.80	26,925.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,430,082.25	213,525.80
MRI SERVICES	311,129.60	4,492.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,984.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	491.50	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	63.00	330,597.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,899.75

TOTAL ANCILLARY	15,256,072.58	978,059.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,256,072.58	978,059.14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	76,521.46	ADJUSTMENTS	0.00
COVERED CHARGES	64,532.51	CONTRACTUAL ALLOW	29,128.16
NON-COVERED CHARGES	11,988.95	TOTAL MEDICAID LIAB	35,404.35
		LESS: COB	35,356.35
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,304.91-
		FEE SCHEDULE-LAB	1,304.91
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 49

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,685.60	0.00
MED/SURG SUPPLY	3,917.06	46.80
LABORATORY-GENERAL	0.00	538.85
RADIOLOGY-DIAGNOSTIC	2,370.00	149.15
CT SCAN	10,069.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	578.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	12,820.50	5,158.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	158.35	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,902.20	25.00
RECOVERY ROOM	2,519.95	0.00
LABORATORY PATHOLOGIC	0.00	52.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	85.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,707.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,536.50	945.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	705.35	0.00
AUDIOLOGY	100.00	0.00
CARDIOLOGY	1,216.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	965.25	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,754.90	1,390.30
MRI SERVICES	1,440.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	254.55
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	726.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	32.00

TOTAL ANCILLARY	64,532.51	9,318.95
TOTAL ACCOMODATIONS	0.00	2,670.00
TOTAL CHARGES	64,532.51	11,988.95

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	893,271.62	ADJUSTMENTS	6,573.00
COVERED CHARGES	876,803.62	CONTRACTUAL ALLOW	791,980.04
NON-COVERED CHARGES	16,468.00	TOTAL MEDICAID LIAB	84,823.58
		LESS: COB	42.42
		LESS: COPAYMENT	2,082.00
		REIMBURSEMENT	82,699.16

TOTAL NUMBER OF CLAIMS 1,696

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,799.80	0.00
MED/SURG SUPPLY	30,228.07	2,895.20
LABORATORY-GENERAL	83,499.00	7,730.85
RADIOLOGY-DIAGNOSTIC	61,752.45	88.75
CT SCAN	31,084.10	1,810.30
PHYSICAL THERAPY	1,326.00	0.00
EKG/ECG	3,819.75	0.00
IV THERAPY	6,675.00	0.00
OPERATING ROOM	10,054.55	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,975.30	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	539,112.70	150.80
RECOVERY ROOM	906.75	0.00
LABORATORY PATHOLOGIC	244.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	300.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,101.60	1,016.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	408.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,827.15	0.00
OTHER LAB SERVICES	6,213.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	283.00	0.00
MRI SERVICES	4,180.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	143.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11.00	2,633.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	876,803.62	16,468.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	876,803.62	16,468.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,502.80	ADJUSTMENTS	0.00
COVERED CHARGES	3,627.40	CONTRACTUAL ALLOW	2,343.99
NON-COVERED CHARGES	875.40	TOTAL MEDICAID LIAB	1,283.41
		LESS: COB	1,274.41
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.30	0.00
MED/SURG SUPPLY	19.40	54.60
LABORATORY-GENERAL	613.45	123.65
RADIOLOGY-DIAGNOSTIC	478.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,340.00	603.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	93.95
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,627.40	875.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,627.40	875.40

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE

WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	730,912.00	ADJUSTMENTS	39,778.88
COVERED CHARGES	711,205.59	CONTRACTUAL ALLOW	522,191.11
NON-COVERED CHARGES	19,706.41	TOTAL MEDICAID LIAB	189,014.48
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	188,924.48

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,328.19	1,353.30
MED/SURG SUPPLY	113,702.91	265.20
LABORATORY-GENERAL	36.75	133.75
RADIOLOGY-DIAGNOSTIC	5,872.85	2,926.00
CT SCAN	10,025.35	926.15
PHYSICAL THERAPY	119.60	0.00
EKG/ECG	4,282.75	0.00
IV THERAPY	11,510.00	0.00
OPERATING ROOM	302,724.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,028.70	0.00
ANESTHESIA	780.00	0.00
GI SERVICES	3,658.75	0.00
EMERGENCY ROOM	17,454.80	0.00
RECOVERY ROOM	19,369.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	130.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,206.40	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,879.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,877.00	315.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,753.75	1,181.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,788.70	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	408.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	54,759.70	0.00
OTHER LAB SERVICES	7,605.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	452.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,331.59	3,346.86
MRI SERVICES	8,569.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	8,806.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	711,205.59	19,706.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	711,205.59	19,706.41

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE

WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,008,255.11	ADJUSTMENTS	394,438.18
COVERED CHARGES	18,792,399.16	CONTRACTUAL ALLOW	11,224,528.95
NON-COVERED CHARGES	215,855.95	TOTAL MEDICAID LIAB	7,567,870.21
		LESS: COB	68,351.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,499,518.43

TOTAL NUMBER OF ADMISSIONS 1,784

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,957	0	1,993,975.00	113,195.00
NURSERY CARE CHARGES	1,052	0	373,995.00	11,360.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	13	0.00	0.00
TOTAL ROUTINE	5,009	13	2,367,970.00	124,555.00
SPECIAL CARE SERVICES				
C C U	488	0	534,125.00	0.00
I C U	509	0	579,175.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	997	0	1,113,300.00	0.00
TOTAL ACCOMODATIONS	6,006	13	3,481,270.00	124,555.00

INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,026,461.18	0.00
MED/SURG SUPPLY	1,784,761.98	1,461.70
LABORATORY-GENERAL	1,427,872.43	457.35
RADIOLOGY-DIAGNOSTIC	316,186.55	0.00
CT SCAN	600,768.80	0.00
PHYSICAL THERAPY	104,548.20	0.00
EKG/ECG	114,546.55	0.00
IV THERAPY	6,251.00	0.00
OPERATING ROOM	2,276,047.37	0.00
LABOR/DELIVERY ROOM	525,700.75	0.00
RESPIRATORY SERVICES	980,365.15	0.00
ANESTHESIA	2,095.00	0.00
GI SERVICES	206,386.55	0.00
EMERGENCY ROOM	602,661.05	0.00
RECOVERY ROOM	156,063.70	0.00
LABORATORY PATHOLOGIC	34,608.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	8,909.40	0.00
SPEECH PATHOLOGY	13,451.60	0.00
RENAL DIALYSIS	257,603.40	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	7,170.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	125,752.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	266,805.15	76,397.05
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	168,626.40	0.00
AUDIOLOGY	54,010.00	0.00
CARDIOLOGY	544,295.35	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	25,389.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	380,802.20	0.00
OTHER LAB SERVICES	107,292.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	183.20	0.00
OTHER THERAPEUTIC SERVI	0.00	3,570.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	192,330.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	223.35
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	941.50
INJECTABLE DRUGS	353.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,080.00

TOTAL ANCILLARY	15,311,129.16	91,300.95
TOTAL ACCOMODATIONS	3,481,270.00	124,555.00
TOTAL CHARGES	18,792,399.16	215,855.95

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	395,531.08	ADJUSTMENTS	0.00
COVERED CHARGES	390,064.63	CONTRACTUAL ALLOW	119,698.22
NON-COVERED CHARGES	5,466.45	TOTAL MEDICAID LIAB	270,366.41
		LESS: COB	270,366.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	104	0	52,300.00	3,560.00
NURSERY CARE CHARGES	10	0	3,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	114	0	55,800.00	3,560.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	16	0	18,400.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	16	0	18,400.00	0.00
TOTAL ACCOMODATIONS	130	0	74,200.00	3,560.00

ZERO PAID INPATIENT PAID CLAIMS

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,852.00	0.00
MED/SURG SUPPLY	50,464.33	126.40
LABORATORY-GENERAL	24,766.65	34.30
RADIOLOGY-DIAGNOSTIC	4,109.00	0.00
CT SCAN	15,816.85	0.00
PHYSICAL THERAPY	3,362.75	0.00
EKG/ECG	1,156.35	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	74,202.75	0.00
LABOR/DELIVERY ROOM	25,860.10	0.00
RESPIRATORY SERVICES	8,986.45	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,815.80	0.00
EMERGENCY ROOM	7,534.00	0.00
RECOVERY ROOM	5,485.85	0.00
LABORATORY PATHOLOGIC	1,243.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	118.40	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,460.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,888.10	1,247.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	330.00	0.00
CARDIOLOGY	8,356.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	404.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,899.80	0.00
OTHER LAB SERVICES	210.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,540.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	379.35
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	119.00

TOTAL ANCILLARY	315,864.63	1,906.45
TOTAL ACCOMODATIONS	74,200.00	3,560.00
TOTAL CHARGES	390,064.63	5,466.45

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,445,466.85	ADJUSTMENTS	129,277.63
COVERED CHARGES	14,656,305.96	CONTRACTUAL ALLOW	10,890,895.51
NON-COVERED CHARGES	789,160.89	TOTAL MEDICAID LIAB	3,765,410.45
		LESS: COB	2,400.59
		LESS: COPAYMENT	15,003.00
		REIMBURSEMENT	3,748,006.86
		ALL OTHER	3,363,904.85
		FEE SCHEDULE-LAB	384,102.01
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13,785

OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	835,603.91	12,702.00
MED/SURG SUPPLY	672,512.01	27,773.55
LABORATORY-GENERAL	0.00	31,450.75
RADIOLOGY-DIAGNOSTIC	674,122.10	10,302.10
CT SCAN	1,038,414.20	90,962.45
PHYSICAL THERAPY	118,684.35	2,105.40
EKG/ECG	177,035.95	127.35
IV THERAPY	43,780.00	2,711.50
OPERATING ROOM	2,325,824.55	99,144.86
LABOR/DELIVERY ROOM	1,658.80	0.00
RESPIRATORY SERVICES	142,458.30	0.00
ANESTHESIA	880.00	0.00
GI SERVICES	457,459.45	0.00
EMERGENCY ROOM	2,371,707.15	3,304.30
RECOVERY ROOM	377,118.75	0.00
LABORATORY PATHOLOGIC	0.00	25.75
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	33,265.85	3,166.30
SPEECH PATHOLOGY	19,655.00	1,245.85
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	110,543.60	2,820.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	68,983.20	0.00
OTHER IMAGING SERVICES	743,179.55	38,100.85
BLOOD	3,329.45	0.00
BLOOD STORAGE & PRO.	37,380.55	17,285.35
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	358,952.50	7,798.50
AUDIOLOGY	497.65	0.00
CARDIOLOGY	691,072.85	34,397.45
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	25,109.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	848,677.90	2,220.30
OTHER LAB SERVICES	332,672.45	1,575.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	588.70	651.40
OTHER THERAPEUTIC SERVI	0.00	945.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,661,931.99	267,126.85
MRI SERVICES	481,800.00	22,180.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,179.40
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,405.95	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	126.00
INJECTABLE DRUGS	0.00	106,255.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,476.85

TOTAL ANCILLARY	14,656,305.96	789,160.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,656,305.96	789,160.89

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	117,490.85	ADJUSTMENTS	0.00
COVERED CHARGES	94,956.40	CONTRACTUAL ALLOW	31,880.43
NON-COVERED CHARGES	22,534.45	TOTAL MEDICAID LIAB	63,075.97
		LESS: COB	62,973.97
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,046.77-
		FEE SCHEDULE-LAB	2,046.77
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,681.84	0.00
MED/SURG SUPPLY	9,260.90	202.90
LABORATORY-GENERAL	0.00	126.05
RADIOLOGY-DIAGNOSTIC	3,598.00	144.00
CT SCAN	4,649.15	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,239.10	0.00
IV THERAPY	176.00	0.00
OPERATING ROOM	17,582.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,435.45	0.00
EMERGENCY ROOM	12,418.30	315.00
RECOVERY ROOM	3,119.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	521.20	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,500.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,455.25	1,563.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,419.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,617.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,090.05	0.00
OTHER LAB SERVICES	498.05	183.05
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	105.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,918.91	2,083.40
MRI SERVICES	1,775.00	5,325.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	223.35
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	12,263.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	94,956.40	22,534.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,956.40	22,534.45

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,075,396.28	ADJUSTMENTS	1,482.00
COVERED CHARGES	1,036,986.23	CONTRACTUAL ALLOW	953,521.65
NON-COVERED CHARGES	38,410.05	TOTAL MEDICAID LIAB	83,464.58
		LESS: COB	0.00
		LESS: COPAYMENT	2,166.00
		REIMBURSEMENT	81,298.58

TOTAL NUMBER OF CLAIMS 1,637

OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,468.44	146.00
MED/SURG SUPPLY	39,620.44	2,217.30
LABORATORY-GENERAL	123,215.50	11,189.20
RADIOLOGY-DIAGNOSTIC	78,413.00	0.00
CT SCAN	56,084.25	19,353.75
PHYSICAL THERAPY	353.50	380.90
EKG/ECG	5,094.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,088.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,153.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	577,789.30	210.00
RECOVERY ROOM	1,141.85	0.00
LABORATORY PATHOLOGIC	140.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	9.20
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	235.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	28,576.85	3,158.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,958.80	935.55
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,931.90	0.00
OTHER LAB SERVICES	2,977.05	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,036.50	0.00
MRI SERVICES	12,645.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	143.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	63.00	666.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,036,986.23	38,410.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,036,986.23	38,410.05

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,998.96	ADJUSTMENTS	0.00
COVERED CHARGES	8,634.65	CONTRACTUAL ALLOW	4,363.30
NON-COVERED CHARGES	1,364.31	TOTAL MEDICAID LIAB	4,271.35
		LESS: COB	4,268.35
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699.25	13.95
MED/SURG SUPPLY	262.53	149.40
LABORATORY-GENERAL	540.22	54.96
RADIOLOGY-DIAGNOSTIC	879.00	145.00
CT SCAN	1,133.15	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,367.50	858.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	753.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	143.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,634.65	1,364.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,634.65	1,364.31

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE

WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	665,547.99	ADJUSTMENTS	10,506.48
COVERED CHARGES	644,168.74	CONTRACTUAL ALLOW	507,350.50
NON-COVERED CHARGES	21,379.25	TOTAL MEDICAID LIAB	136,818.24
		LESS: COB	0.00
		LESS: COPAYMENT	135.00
		REIMBURSEMENT	136,683.24

TOTAL NUMBER OF CLAIMS 39

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0083GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,416.93	0.00
MED/SURG SUPPLY	77,502.51	3,054.90
LABORATORY-GENERAL	0.00	227.10
RADIOLOGY-DIAGNOSTIC	13,408.30	825.00
CT SCAN	27,923.60	3,604.95
PHYSICAL THERAPY	468.50	0.00
EKG/ECG	5,631.45	0.00
IV THERAPY	654.50	242.00
OPERATING ROOM	263,061.15	489.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,568.15	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,384.55	0.00
RECOVERY ROOM	12,962.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	735.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,974.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,205.10	311.85
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,787.55	1,299.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	44,054.00	292.05
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	65,284.20	257.40
OTHER LAB SERVICES	6,023.85	315.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,121.80	7,101.95
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,357.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	644,168.74	21,379.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	644,168.74	21,379.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,407.80	ADJUSTMENTS	0.00
COVERED CHARGES	15,398.60	CONTRACTUAL ALLOW	6,156.58
NON-COVERED CHARGES	9.20	TOTAL MEDICAID LIAB	9,242.02
		LESS: COB	9,242.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SATILLA REG MEDCENTER
410 DARLING AVENUE
WAYCROSS GA 31501-5246

PROVIDER NUMBER 000001229A
NUMBER OF BEDS 257
TITLE XVIII NO: HPH0083GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	422.75	0.00
MED/SURG SUPPLY	7,140.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	275.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	6,752.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	764.05	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44.00	9.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	15,398.60	9.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,398.60	9.20

INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	217,938.51	ADJUSTMENTS	57,067.06
COVERED CHARGES	209,853.51	CONTRACTUAL ALLOW	20,963.79
NON-COVERED CHARGES	8,085.00	TOTAL MEDICAID LIAB	188,889.72
		LESS: COB	1,387.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	187,502.35

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	147	0	75,264.00	8,085.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	147	0	75,264.00	8,085.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	147	0	75,264.00	8,085.00

INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,622.30	0.00
MED/SURG SUPPLY	21,114.91	0.00
LABORATORY-GENERAL	15,999.50	0.00
RADIOLOGY-DIAGNOSTIC	7,049.00	0.00
CT SCAN	8,909.00	0.00
PHYSICAL THERAPY	610.00	0.00
EKG/ECG	1,638.00	0.00
IV THERAPY	7,594.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,040.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,786.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,934.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,274.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	337.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	750.00	0.00
OTHER LAB SERVICES	648.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,282.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	134,589.51	0.00
TOTAL ACCOMODATIONS	75,264.00	8,085.00
TOTAL CHARGES	209,853.51	8,085.00

ZERO PAID INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	937,072.47	ADJUSTMENTS	9,757.96
COVERED CHARGES	881,458.78	CONTRACTUAL ALLOW	342,552.00
NON-COVERED CHARGES	55,613.69	TOTAL MEDICAID LIAB	538,906.78
		LESS: COB	1,179.15
		LESS: COPAYMENT	2,601.00
		REIMBURSEMENT	535,126.63
		ALL OTHER	495,576.63
		FEE SCHEDULE-LAB	36,458.40
		INJECTABLE DRUGS	3,091.60

TOTAL NUMBER OF CLAIMS 2,473

OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,310.16	922.70
MED/SURG SUPPLY	31,728.36	0.00
LABORATORY-GENERAL	0.00	5,368.79
RADIOLOGY-DIAGNOSTIC	111,556.55	990.00
CT SCAN	74,952.50	0.00
PHYSICAL THERAPY	23,912.50	430.50
EKG/ECG	15,858.50	0.00
IV THERAPY	16,899.00	0.00
OPERATING ROOM	20,508.50	3,085.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,887.00	0.00
ANESTHESIA	169.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	290,904.50	774.50
RECOVERY ROOM	6,534.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	60,898.40	337.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	379.00	258.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,348.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	34,117.50	972.00
OTHER LAB SERVICES	5,041.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	140,909.93	37,692.55
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,543.38	4,703.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	79.00

TOTAL ANCILLARY	881,458.78	55,613.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	881,458.78	55,613.69

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,951.48	ADJUSTMENTS	0.00
COVERED CHARGES	10,243.08	CONTRACTUAL ALLOW	1,814.26
NON-COVERED CHARGES	1,708.40	TOTAL MEDICAID LIAB	8,428.82
		LESS: COB	8,407.82
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	878.90-
		FEE SCHEDULE-LAB	762.15
		INJECTABLE DRUGS	116.75

TOTAL NUMBER OF CLAIMS 62

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385.00	15.00
MED/SURG SUPPLY	312.88	0.00
LABORATORY-GENERAL	0.00	9.50
RADIOLOGY-DIAGNOSTIC	832.50	0.00
CT SCAN	751.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	182.00	0.00
IV THERAPY	410.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,475.50	141.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	762.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,964.60	909.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	167.10	633.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,243.08	1,708.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,243.08	1,708.40

OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	117,734.42	ADJUSTMENTS	350.00
COVERED CHARGES	115,282.37	CONTRACTUAL ALLOW	95,851.37
NON-COVERED CHARGES	2,452.05	TOTAL MEDICAID LIAB	19,431.00
		LESS: COB	58.10
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	19,135.90

TOTAL NUMBER OF CLAIMS 389

OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,054.55	0.00
MED/SURG SUPPLY	1,161.02	0.00
LABORATORY-GENERAL	9,499.00	863.00
RADIOLOGY-DIAGNOSTIC	4,531.00	0.00
CT SCAN	751.50	0.00
PHYSICAL THERAPY	384.00	0.00
EKG/ECG	910.00	0.00
IV THERAPY	875.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	120.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,896.50	31.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	414.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,685.80	1,521.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	36.50

TOTAL ANCILLARY	115,282.37	2,452.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,282.37	2,452.05

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,671.55	ADJUSTMENTS	0.00
COVERED CHARGES	1,552.05	CONTRACTUAL ALLOW	965.17
NON-COVERED CHARGES	119.50	TOTAL MEDICAID LIAB	586.88
		LESS: COB	586.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194.35	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	230.50	9.50
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,006.50	110.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	92.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,552.05	119.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,552.05	119.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	248,676.49	ADJUSTMENTS	5,565.81
COVERED CHARGES	240,145.49	CONTRACTUAL ALLOW	22,160.14
NON-COVERED CHARGES	8,531.00	TOTAL MEDICAID LIAB	217,985.35
		LESS: COB	2,478.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	215,507.24

TOTAL NUMBER OF ADMISSIONS 46

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	152	0	86,184.00	7,695.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	152	0	86,184.00	7,695.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	152	0	86,184.00	7,695.00

INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,586.55	0.00
MED/SURG SUPPLY	35,729.14	0.00
LABORATORY-GENERAL	18,189.00	0.00
RADIOLOGY-DIAGNOSTIC	6,294.00	0.00
CT SCAN	2,242.00	0.00
PHYSICAL THERAPY	147.00	0.00
EKG/ECG	2,891.00	0.00
IV THERAPY	8,667.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,080.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,529.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,294.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	284.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46.00	0.00
OTHER LAB SERVICES	756.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,226.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	836.00

TOTAL ANCILLARY	153,961.49	836.00
TOTAL ACCOMODATIONS	86,184.00	7,695.00
TOTAL CHARGES	240,145.49	8,531.00

ZERO PAID INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,100,654.74	ADJUSTMENTS	4,183.48
COVERED CHARGES	1,004,062.82	CONTRACTUAL ALLOW	385,893.77
NON-COVERED CHARGES	96,591.92	TOTAL MEDICAID LIAB	618,169.05
		LESS: COB	2,820.41
		LESS: COPAYMENT	2,658.00
		REIMBURSEMENT	612,690.64
		ALL OTHER	564,200.51
		FEE SCHEDULE-LAB	39,744.46
		INJECTABLE DRUGS	8,745.67

TOTAL NUMBER OF CLAIMS 2,579

OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,387.94	169.00
MED/SURG SUPPLY	36,985.49	0.00
LABORATORY-GENERAL	0.00	1,980.00
RADIOLOGY-DIAGNOSTIC	124,223.50	2,100.00
CT SCAN	60,578.00	14,297.00
PHYSICAL THERAPY	19,841.50	3,107.00
EKG/ECG	18,792.00	400.00
IV THERAPY	17,825.00	4,818.00
OPERATING ROOM	39,907.00	2,928.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,692.00	44.00
ANESTHESIA	372.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	325,891.50	8,835.50
RECOVERY ROOM	9,177.00	67.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	57,847.00	316.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,934.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	49,370.00	2,874.50
OTHER LAB SERVICES	6,306.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	171,297.03	54,655.92
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,635.86	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,004,062.82	96,591.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,004,062.82	96,591.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,569.47	ADJUSTMENTS	0.00
COVERED CHARGES	4,120.26	CONTRACTUAL ALLOW	618.40
NON-COVERED CHARGES	449.21	TOTAL MEDICAID LIAB	3,501.86
		LESS: COB	3,486.86
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	527.39-
		FEE SCHEDULE-LAB	502.24
		INJECTABLE DRUGS	25.15

TOTAL NUMBER OF CLAIMS 28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	0.00
MED/SURG SUPPLY	107.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,836.00	34.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,480.26	415.21
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,120.26	449.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,120.26	449.21

OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	179,776.82	ADJUSTMENTS	194.00
COVERED CHARGES	175,516.32	CONTRACTUAL ALLOW	149,240.32
NON-COVERED CHARGES	4,260.50	TOTAL MEDICAID LIAB	26,276.00
		LESS: COB	0.00
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	25,739.00

TOTAL NUMBER OF CLAIMS 528

OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,208.55	0.00
MED/SURG SUPPLY	1,428.15	0.00
LABORATORY-GENERAL	13,217.50	1,789.50
RADIOLOGY-DIAGNOSTIC	5,180.00	0.00
CT SCAN	1,638.00	0.00
PHYSICAL THERAPY	466.00	86.00
EKG/ECG	882.00	0.00
IV THERAPY	2,316.00	330.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	220.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	134,053.00	1,487.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	426.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,029.50	0.00
OTHER LAB SERVICES	378.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,499.62	18.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	124.00

TOTAL ANCILLARY	175,516.32	4,260.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	175,516.32	4,260.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,338.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,018.00	CONTRACTUAL ALLOW	3,846.16
NON-COVERED CHARGES	1,320.00	TOTAL MEDICAID LIAB	1,171.84
		LESS: COB	1,168.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	959.00	0.00
MED/SURG SUPPLY	128.00	0.00
LABORATORY-GENERAL	960.00	91.00
RADIOLOGY-DIAGNOSTIC	496.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,034.00	1,229.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	648.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	612.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	181.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,018.00	1,320.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,018.00	1,320.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	31,844.00	ADJUSTMENTS	0.00
COVERED CHARGES	31,120.00	CONTRACTUAL ALLOW	10,652.56
NON-COVERED CHARGES	724.00	TOTAL MEDICAID LIAB	20,467.44
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	20,449.44

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: 111312

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,569.00	54.00
MED/SURG SUPPLY	7,189.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	438.00	660.00
OPERATING ROOM	15,284.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	186.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,394.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36.00	10.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	31,120.00	724.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,120.00	724.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSP
215 MIMS RD
SYLVANIA GA 30467-1994

PROVIDER NUMBER 000001647A
NUMBER OF BEDS 49
TITLE XVIII NO: 111312

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,370,871.62	ADJUSTMENTS	16,575.10
COVERED CHARGES	3,325,505.62	CONTRACTUAL ALLOW	1,061,321.53
NON-COVERED CHARGES	45,366.00	TOTAL MEDICAID LIAB	2,264,184.09
		LESS: COB	21,213.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,242,970.40

TOTAL NUMBER OF ADMISSIONS 661

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,412	0	451,840.00	37,906.00
NURSERY CARE CHARGES	443	0	105,598.00	52.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,855	0	557,438.00	37,958.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,855	0	557,438.00	37,958.00

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	598,765.38	0.00
MED/SURG SUPPLY	404,470.04	222.00
LABORATORY-GENERAL	293,084.45	2,095.00
RADIOLOGY-DIAGNOSTIC	37,333.00	0.00
CT SCAN	155,651.00	855.00
PHYSICAL THERAPY	2,815.00	0.00
EKG/ECG	112,142.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	270,747.00	0.00
LABOR/DELIVERY ROOM	453,048.00	0.00
RESPIRATORY SERVICES	56,134.00	0.00
ANESTHESIA	78,674.00	0.00
GI SERVICES	13,833.00	0.00
EMERGENCY ROOM	43,780.00	0.00
RECOVERY ROOM	68,065.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	194.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,713.00	0.00
OTHER IMAGING SERVICES	22,183.00	135.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,886.00	3,185.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,022.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,138.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,606.00	0.00
OTHER LAB SERVICES	8,858.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	405.00
SPECIAL CHARGES	2,056.75	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	15,066.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,803.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	511.00

TOTAL ANCILLARY	2,768,067.62	7,408.00
TOTAL ACCOMODATIONS	557,438.00	37,958.00
TOTAL CHARGES	3,325,505.62	45,366.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	52,566.00	ADJUSTMENTS	0.00
COVERED CHARGES	52,046.00	CONTRACTUAL ALLOW	7,725.44
NON-COVERED CHARGES	520.00	TOTAL MEDICAID LIAB	44,320.56
		LESS: COB	44,320.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	20	0	6,400.00	520.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20	0	6,400.00	520.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	20	0	6,400.00	520.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,850.00	0.00
MED/SURG SUPPLY	10,944.00	0.00
LABORATORY-GENERAL	2,343.00	0.00
RADIOLOGY-DIAGNOSTIC	551.00	0.00
CT SCAN	2,191.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	233.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,543.00	0.00
LABOR/DELIVERY ROOM	2,873.00	0.00
RESPIRATORY SERVICES	288.00	0.00
ANESTHESIA	2,914.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,036.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	324.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	556.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	45,646.00	0.00
TOTAL ACCOMODATIONS	6,400.00	520.00
TOTAL CHARGES	52,046.00	520.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,830,737.09	ADJUSTMENTS	944,250.46
COVERED CHARGES	5,867,394.86	CONTRACTUAL ALLOW	3,293,374.08
NON-COVERED CHARGES	963,342.23	TOTAL MEDICAID LIAB	2,574,020.78
		LESS: COB	3,740.15
		LESS: COPAYMENT	3,528.00
		REIMBURSEMENT	2,566,752.63
		ALL OTHER	2,502,531.90
		FEE SCHEDULE-LAB	62,217.12
		INJECTABLE DRUGS	2,003.61

TOTAL NUMBER OF CLAIMS 4,292

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498,280.40	39,129.00
MED/SURG SUPPLY	1,061,684.51	45,195.00
LABORATORY-GENERAL	0.00	47,436.00
RADIOLOGY-DIAGNOSTIC	186,775.00	20,117.00
CT SCAN	236,819.00	17,229.00
PHYSICAL THERAPY	0.00	373.00
EKG/ECG	86,566.50	4,186.00
IV THERAPY	0.00	38.00
OPERATING ROOM	1,631,824.00	603,984.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,694.00	532.00
ANESTHESIA	492,803.00	17,952.00
GI SERVICES	14,703.00	2,385.00
EMERGENCY ROOM	384,622.01	24,295.00
RECOVERY ROOM	355,711.00	12,287.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	86.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	120.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	13,344.00	0.00
OTHER IMAGING SERVICES	110,634.00	4,469.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	618.00	1,345.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,825.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	63,268.00	12,213.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	49,839.00	1,696.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	72,311.00	3,546.00
OTHER LAB SERVICES	16,757.00	842.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,283.00
SPECIAL CHARGES	6,010.50	0.00
FEE SCHEDULE LAB	316,433.94	72,912.73
MRI SERVICES	228,044.00	24,799.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	702.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,622.00	3,679.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	25.00

TOTAL ANCILLARY	5,867,394.86	962,650.23
TOTAL ACCOMODATIONS	0.00	692.00
TOTAL CHARGES	5,867,394.86	963,342.23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	81,544.05	ADJUSTMENTS	0.00
COVERED CHARGES	74,799.05	CONTRACTUAL ALLOW	16,073.69
NON-COVERED CHARGES	6,745.00	TOTAL MEDICAID LIAB	58,725.36
		LESS: COB	58,692.36
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,130.86-
		FEE SCHEDULE-LAB	1,095.54
		INJECTABLE DRUGS	35.32

TOTAL NUMBER OF CLAIMS 68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,466.00	120.00
MED/SURG SUPPLY	11,645.05	0.00
LABORATORY-GENERAL	0.00	764.00
RADIOLOGY-DIAGNOSTIC	812.00	104.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	466.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	16,121.00	3,752.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	680.00	143.00
ANESTHESIA	8,976.00	0.00
GI SERVICES	2,385.00	0.00
EMERGENCY ROOM	6,994.00	432.00
RECOVERY ROOM	6,938.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,370.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	120.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,313.00	0.00
OTHER LAB SERVICES	38.00	120.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,323.00	979.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	135.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	272.00	61.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	74,799.05	6,730.00
TOTAL ACCOMODATIONS	0.00	15.00
TOTAL CHARGES	74,799.05	6,745.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	193,128.50	ADJUSTMENTS	385.00
COVERED CHARGES	182,320.50	CONTRACTUAL ALLOW	159,428.50
NON-COVERED CHARGES	10,808.00	TOTAL MEDICAID LIAB	22,892.00
		LESS: COB	45.69
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	22,357.31

TOTAL NUMBER OF CLAIMS 490

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,007.00	0.00
MED/SURG SUPPLY	4,531.00	475.00
LABORATORY-GENERAL	26,852.50	4,631.00
RADIOLOGY-DIAGNOSTIC	8,802.00	278.00
CT SCAN	870.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,796.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,544.00	0.00
LABOR/DELIVERY ROOM	2,333.00	0.00
RESPIRATORY SERVICES	819.00	0.00
ANESTHESIA	1,632.00	0.00
GI SERVICES	1,272.00	0.00
EMERGENCY ROOM	105,532.00	5,243.00
RECOVERY ROOM	1,018.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	43.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,184.00	15.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,590.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,195.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	55.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,343.00	68.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	182,320.50	10,808.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	182,320.50	10,808.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,787.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,483.00	CONTRACTUAL ALLOW	838.50
NON-COVERED CHARGES	1,304.00	TOTAL MEDICAID LIAB	644.50
		LESS: COB	638.50
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.00	13.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	444.00	605.00
RADIOLOGY-DIAGNOSTIC	238.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	712.00	686.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,483.00	1,304.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,483.00	1,304.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD

VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	695,548.10	ADJUSTMENTS	132,702.74
COVERED CHARGES	678,627.10	CONTRACTUAL ALLOW	413,215.62
NON-COVERED CHARGES	16,921.00	TOTAL MEDICAID LIAB	265,411.48
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	265,375.48

TOTAL NUMBER OF CLAIMS 58

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,521.00	1,882.00
MED/SURG SUPPLY	148,346.10	0.00
LABORATORY-GENERAL	0.00	105.00
RADIOLOGY-DIAGNOSTIC	1,067.00	0.00
CT SCAN	1,115.00	0.00
PHYSICAL THERAPY	0.00	188.00
EKG/ECG	233.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	306,637.00	11,715.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,594.00	0.00
ANESTHESIA	46,612.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	35,074.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	99,659.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	2,900.00
TREATMENT/OBSERVATION	3,255.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	966.00	49.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	548.00	82.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	678,627.10	16,921.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	678,627.10	16,921.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,822,109.74	ADJUSTMENTS	181,666.62
COVERED CHARGES	4,722,454.74	CONTRACTUAL ALLOW	1,882,294.36
NON-COVERED CHARGES	99,655.00	TOTAL MEDICAID LIAB	2,840,160.38
		LESS: COB	37,806.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,802,353.42

TOTAL NUMBER OF ADMISSIONS 864

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,754	0	607,736.00	87,821.00
NURSERY CARE CHARGES	629	0	160,683.00	654.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,383	0	768,419.00	88,475.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,383	0	768,419.00	88,475.00

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	916,921.48	0.00
MED/SURG SUPPLY	589,679.50	147.00
LABORATORY-GENERAL	405,731.01	5,236.00
RADIOLOGY-DIAGNOSTIC	49,300.00	0.00
CT SCAN	175,035.00	0.00
PHYSICAL THERAPY	1,980.00	0.00
EKG/ECG	138,984.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	344,007.00	0.00
LABOR/DELIVERY ROOM	670,102.00	0.00
RESPIRATORY SERVICES	116,851.00	0.00
ANESTHESIA	106,434.00	0.00
GI SERVICES	31,314.00	0.00
EMERGENCY ROOM	42,474.00	0.00
RECOVERY ROOM	91,958.00	0.00
LABORATORY PATHOLOGIC	352.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,524.00	0.00
SPEECH PATHOLOGY	344.00	0.00
RENAL DIALYSIS	700.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,900.00	0.00
OTHER IMAGING SERVICES	33,823.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,976.00	5,688.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,297.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	65,513.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	413.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,219.00	0.00
OTHER LAB SERVICES	9,128.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	22,283.75	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	17,364.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	109.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,428.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,954,035.74	11,180.00
TOTAL ACCOMODATIONS	768,419.00	88,475.00
TOTAL CHARGES	4,722,454.74	99,655.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	150,865.50	ADJUSTMENTS	0.00
COVERED CHARGES	150,489.50	CONTRACTUAL ALLOW	62,341.59
NON-COVERED CHARGES	376.00	TOTAL MEDICAID LIAB	88,147.91
		LESS: COB	88,147.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	53	0	19,075.00	376.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	53	0	19,075.00	376.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	53	0	19,075.00	376.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,341.00	0.00
MED/SURG SUPPLY	15,025.50	0.00
LABORATORY-GENERAL	9,214.00	0.00
RADIOLOGY-DIAGNOSTIC	572.00	0.00
CT SCAN	8,939.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,504.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,701.00	0.00
LABOR/DELIVERY ROOM	33,495.00	0.00
RESPIRATORY SERVICES	442.00	0.00
ANESTHESIA	2,287.00	0.00
GI SERVICES	2,672.00	0.00
EMERGENCY ROOM	1,335.00	0.00
RECOVERY ROOM	2,290.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	988.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,916.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,007.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	624.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	62.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	131,414.50	0.00
TOTAL ACCOMODATIONS	19,075.00	376.00
TOTAL CHARGES	150,489.50	376.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,720,554.08	ADJUSTMENTS	567,981.25
COVERED CHARGES	6,467,705.78	CONTRACTUAL ALLOW	3,970,881.85
NON-COVERED CHARGES	252,848.30	TOTAL MEDICAID LIAB	2,496,823.93
		LESS: COB	1,772.61
		LESS: COPAYMENT	3,732.00
		REIMBURSEMENT	2,491,319.32
		ALL OTHER	2,412,508.83
		FEE SCHEDULE-LAB	76,151.29
		INJECTABLE DRUGS	2,659.20

TOTAL NUMBER OF CLAIMS 4,706

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	663,465.48	14,544.00
MED/SURG SUPPLY	1,373,988.44	7,483.00
LABORATORY-GENERAL	404.00	8,466.00
RADIOLOGY-DIAGNOSTIC	236,671.00	6,117.00
CT SCAN	279,543.00	10,033.00
PHYSICAL THERAPY	64.00	599.00
EKG/ECG	120,510.00	0.00
IV THERAPY	0.00	80.00
OPERATING ROOM	1,277,140.00	85,058.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,580.00	0.00
ANESTHESIA	643,974.00	0.00
GI SERVICES	24,776.00	3,478.00
EMERGENCY ROOM	392,141.00	2,524.00
RECOVERY ROOM	462,815.00	555.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	103,631.00	1,751.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,327.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,363.00	943.00
AUDIOLOGY	120.00	0.00
CARDIOLOGY	102,439.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	122,074.01	365.00
OTHER LAB SERVICES	75,309.00	1,288.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	527.00	0.00
FEE SCHEDULE LAB	374,895.85	91,571.30
MRI SERVICES	152,360.00	4,632.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	532.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,453.00
INJECTABLE DRUGS	6,915.00	1,966.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,928.00

TOTAL ANCILLARY	6,467,705.78	251,693.30
TOTAL ACCOMODATIONS	0.00	1,155.00
TOTAL CHARGES	6,467,705.78	252,848.30

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	96,600.50	ADJUSTMENTS	0.00
COVERED CHARGES	90,435.50	CONTRACTUAL ALLOW	22,793.65
NON-COVERED CHARGES	6,165.00	TOTAL MEDICAID LIAB	67,641.85
		LESS: COB	67,611.85
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,565.17-
		FEE SCHEDULE-LAB	1,502.26
		INJECTABLE DRUGS	62.91

TOTAL NUMBER OF CLAIMS 86

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,622.00	155.00
MED/SURG SUPPLY	10,267.50	3.00
LABORATORY-GENERAL	0.00	96.00
RADIOLOGY-DIAGNOSTIC	2,850.00	0.00
CT SCAN	4,776.00	932.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,524.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18,330.00	2,051.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	397.00	0.00
ANESTHESIA	5,842.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,343.00	160.00
RECOVERY ROOM	5,275.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,526.00	16.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,007.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,422.00	0.00
OTHER LAB SERVICES	4,170.00	131.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,916.00	1,489.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	674.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	168.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	70.00

TOTAL ANCILLARY	90,435.50	5,777.00
TOTAL ACCOMODATIONS	0.00	388.00
TOTAL CHARGES	90,435.50	6,165.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	185,887.56	ADJUSTMENTS	1,463.00
COVERED CHARGES	180,849.56	CONTRACTUAL ALLOW	154,610.56
NON-COVERED CHARGES	5,038.00	TOTAL MEDICAID LIAB	26,239.00
		LESS: COB	11.20
		LESS: COPAYMENT	861.00
		REIMBURSEMENT	25,366.80

TOTAL NUMBER OF CLAIMS 536

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,026.00	33.00
MED/SURG SUPPLY	2,519.00	0.00
LABORATORY-GENERAL	20,413.56	3,369.00
RADIOLOGY-DIAGNOSTIC	10,494.00	276.00
CT SCAN	7,469.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,808.00	0.00
IV THERAPY	0.00	122.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,488.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	106,014.00	720.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,545.00	80.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,007.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,647.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	150.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	419.00	227.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	61.00

TOTAL ANCILLARY	180,849.56	5,038.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,849.56	5,038.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,607.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,284.00	CONTRACTUAL ALLOW	1,973.02
NON-COVERED CHARGES	323.00	TOTAL MEDICAID LIAB	1,310.98
		LESS: COB	1,298.98
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	735.00	0.00
MED/SURG SUPPLY	51.00	0.00
LABORATORY-GENERAL	123.00	43.00
RADIOLOGY-DIAGNOSTIC	130.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	85.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,160.00	280.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,284.00	323.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,284.00	323.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD

VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	734,439.50	ADJUSTMENTS	25,467.51
COVERED CHARGES	725,914.50	CONTRACTUAL ALLOW	535,074.47
NON-COVERED CHARGES	8,525.00	TOTAL MEDICAID LIAB	190,840.03
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	190,747.03

TOTAL NUMBER OF CLAIMS 43

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,550.00	1,923.00
MED/SURG SUPPLY	214,762.50	94.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,410.00	2,084.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	236.00
EKG/ECG	3,284.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	269,195.00	3,078.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,863.00	0.00
ANESTHESIA	37,847.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,169.00	0.00
RECOVERY ROOM	27,074.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	180.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	113,088.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,800.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,990.00	785.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	882.00	145.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	725,914.50	8,525.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	725,914.50	8,525.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,875,430.79	ADJUSTMENTS	105,001.86
COVERED CHARGES	4,764,072.79	CONTRACTUAL ALLOW	2,039,285.94
NON-COVERED CHARGES	111,358.00	TOTAL MEDICAID LIAB	2,724,786.85
		LESS: COB	32,272.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,692,513.87

TOTAL NUMBER OF ADMISSIONS 880

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,545	0	565,943.00	95,293.00
NURSERY CARE CHARGES	676	0	184,254.08	1,564.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,221	0	750,197.08	96,857.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	6,900.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	6,900.00	0.00
TOTAL ACCOMODATIONS	2,224	0	757,097.08	96,857.00

INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	944,512.88	0.00
MED/SURG SUPPLY	592,594.60	0.00
LABORATORY-GENERAL	470,823.51	0.00
RADIOLOGY-DIAGNOSTIC	48,482.24	0.00
CT SCAN	121,398.21	0.00
PHYSICAL THERAPY	841.00	0.00
EKG/ECG	147,111.00	0.00
IV THERAPY	5,268.00	0.00
OPERATING ROOM	313,292.00	0.00
LABOR/DELIVERY ROOM	791,296.00	4,950.00
RESPIRATORY SERVICES	74,119.00	0.00
ANESTHESIA	95,211.00	0.00
GI SERVICES	28,484.00	0.00
EMERGENCY ROOM	22,579.00	0.00
RECOVERY ROOM	83,410.00	0.00
LABORATORY PATHOLOGIC	285.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	506.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	34,381.00	0.00
BLOOD	1,011.00	0.00
BLOOD STORAGE & PRO.	11,121.00	8,326.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,202.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	76,512.27	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	442.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,688.00	0.00
OTHER LAB SERVICES	8,852.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	15,946.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,536.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,071.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,071.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	154.00

TOTAL ANCILLARY	4,006,975.71	14,501.00
TOTAL ACCOMODATIONS	757,097.08	96,857.00
TOTAL CHARGES	4,764,072.79	111,358.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	68,953.50	ADJUSTMENTS	0.00
COVERED CHARGES	67,941.50	CONTRACTUAL ALLOW	17,627.11
NON-COVERED CHARGES	1,012.00	TOTAL MEDICAID LIAB	50,314.39
		LESS: COB	50,314.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	27	0	9,909.00	787.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27	0	9,909.00	787.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	27	0	9,909.00	787.00

ZERO PAID INPATIENT PAID CLAIMS

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,269.00	0.00
MED/SURG SUPPLY	7,509.50	0.00
LABORATORY-GENERAL	4,192.00	0.00
RADIOLOGY-DIAGNOSTIC	140.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,128.00	0.00
LABOR/DELIVERY ROOM	15,835.00	225.00
RESPIRATORY SERVICES	1,866.00	0.00
ANESTHESIA	2,449.00	0.00
GI SERVICES	2,292.00	0.00
EMERGENCY ROOM	371.00	0.00
RECOVERY ROOM	1,932.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,364.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	156.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	529.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	58,032.50	225.00
TOTAL ACCOMODATIONS	9,909.00	787.00
TOTAL CHARGES	67,941.50	1,012.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,939,463.02	ADJUSTMENTS	119,907.91
COVERED CHARGES	5,497,104.91	CONTRACTUAL ALLOW	3,843,364.54
NON-COVERED CHARGES	442,358.11	TOTAL MEDICAID LIAB	1,653,740.37
		LESS: COB	4,604.62
		LESS: COPAYMENT	3,663.00
		REIMBURSEMENT	1,645,472.75
		ALL OTHER	1,532,561.74
		FEE SCHEDULE-LAB	110,255.84
		INJECTABLE DRUGS	2,655.17

TOTAL NUMBER OF CLAIMS 4,989

OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	541,363.68	8,673.00
MED/SURG SUPPLY	913,157.50	7,764.00
LABORATORY-GENERAL	860.01	48,540.00
RADIOLOGY-DIAGNOSTIC	297,080.92	4,599.00
CT SCAN	190,221.26	34,911.10
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	84,215.00	0.00
IV THERAPY	17,701.00	621.00
OPERATING ROOM	1,033,882.00	75,314.00
LABOR/DELIVERY ROOM	18,387.00	0.00
RESPIRATORY SERVICES	24,443.00	460.00
ANESTHESIA	483,898.00	0.00
GI SERVICES	20,707.00	0.00
EMERGENCY ROOM	314,985.00	15,958.00
RECOVERY ROOM	388,525.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	986.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,900.00	0.00
OTHER IMAGING SERVICES	102,453.00	4,343.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	5,876.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,268.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	43,667.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	698.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	167,960.00	10,150.00
OTHER LAB SERVICES	58,235.00	2,161.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	501.00	0.00
FEE SCHEDULE LAB	709,700.54	212,776.01
MRI SERVICES	54,384.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	453.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,912.00	3,804.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,823.00

TOTAL ANCILLARY	5,497,104.91	441,212.11
TOTAL ACCOMODATIONS	0.00	1,146.00
TOTAL CHARGES	5,497,104.91	442,358.11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	110,374.01	ADJUSTMENTS	0.00
COVERED CHARGES	99,649.01	CONTRACTUAL ALLOW	35,620.75
NON-COVERED CHARGES	10,725.00	TOTAL MEDICAID LIAB	64,028.26
		LESS: COB	63,995.26
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,008.74-
		FEE SCHEDULE-LAB	1,990.32
		INJECTABLE DRUGS	18.42

TOTAL NUMBER OF CLAIMS 93

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,021.00	238.00
MED/SURG SUPPLY	8,736.00	151.00
LABORATORY-GENERAL	0.00	1,279.00
RADIOLOGY-DIAGNOSTIC	5,428.00	756.00
CT SCAN	2,649.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	544.00	0.00
IV THERAPY	188.00	0.00
OPERATING ROOM	18,200.00	1,662.00
LABOR/DELIVERY ROOM	1,125.00	0.00
RESPIRATORY SERVICES	273.00	0.00
ANESTHESIA	6,121.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,230.00	120.00
RECOVERY ROOM	5,014.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,900.00	0.00
OTHER IMAGING SERVICES	2,635.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,782.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,122.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,855.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,608.00	96.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,283.01	2,967.00
MRI SERVICES	1,648.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	910.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	69.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	99,649.01	9,961.00
TOTAL ACCOMODATIONS	0.00	764.00
TOTAL CHARGES	99,649.01	10,725.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	155,815.71	ADJUSTMENTS	1,826.75
COVERED CHARGES	147,964.71	CONTRACTUAL ALLOW	128,428.42
NON-COVERED CHARGES	7,851.00	TOTAL MEDICAID LIAB	19,536.29
		LESS: COB	61.19
		LESS: COPAYMENT	492.00
		REIMBURSEMENT	18,983.10

TOTAL NUMBER OF CLAIMS 388

OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,154.64	69.00
MED/SURG SUPPLY	1,980.00	0.00
LABORATORY-GENERAL	26,950.06	4,279.00
RADIOLOGY-DIAGNOSTIC	10,205.00	0.00
CT SCAN	5,029.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,448.00	0.00
IV THERAPY	2,186.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,274.00	190.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	77,549.01	2,922.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,598.00	391.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	617.00	0.00
OTHER LAB SERVICES	354.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,188.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	432.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	147,964.71	7,851.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,964.71	7,851.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,440.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,316.00	CONTRACTUAL ALLOW	1,552.33
NON-COVERED CHARGES	124.00	TOTAL MEDICAID LIAB	1,763.67
		LESS: COB	1,757.67
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	967.00	84.00
RADIOLOGY-DIAGNOSTIC	356.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	272.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,088.00	40.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	449.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,316.00	124.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,316.00	124.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD

VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	300,661.68	ADJUSTMENTS	3,914.11
COVERED CHARGES	283,886.68	CONTRACTUAL ALLOW	209,461.59
NON-COVERED CHARGES	16,775.00	TOTAL MEDICAID LIAB	74,425.09
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	74,353.09

TOTAL NUMBER OF CLAIMS 19

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 08BBXRH

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,622.08	531.00
MED/SURG SUPPLY	32,993.50	10,639.00
LABORATORY-GENERAL	0.00	146.00
RADIOLOGY-DIAGNOSTIC	1,350.00	504.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,395.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	121,757.00	4,086.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	322.00	0.00
ANESTHESIA	17,681.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	13,068.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	46,700.00	0.00
OTHER IMAGING SERVICES	363.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,122.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,148.09	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,283.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,036.01	663.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46.00	206.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	283,886.68	16,775.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	283,886.68	16,775.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH NORTHVIEW HOSPITAL
4280 NORTH VALDOSTA ROAD
VALDOSTA GA 31602-6814

PROVIDER NUMBER 000001691A
NUMBER OF BEDS 71
TITLE XVIII NO: 08BBXRH

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,133,269.59	ADJUSTMENTS	11,316,136.28
COVERED CHARGES	65,452,888.99	CONTRACTUAL ALLOW	41,048,042.07
NON-COVERED CHARGES	1,680,380.60	TOTAL MEDICAID LIAB	24,404,846.92
		LESS: COB	81,023.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,323,823.16

TOTAL NUMBER OF ADMISSIONS 3,900

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,240	968	3,775,200.00	866,068.00
NURSERY CARE CHARGES	3,113	0	1,531,295.00	693,518.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	0.00
TOTAL ROUTINE	9,353	974	5,306,495.00	1,559,586.00
SPECIAL CARE SERVICES				
C C U	2,711	0	2,855,931.00	0.00
I C U	1,278	0	2,376,696.00	0.00
N I C U	1,692	0	2,765,830.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	81	0.00	63,099.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,681	81	7,998,457.00	63,099.00
TOTAL ACCOMODATIONS	15,034	1,055	13,304,952.00	1,622,685.00

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,643,418.66	0.00
MED/SURG SUPPLY	5,575,424.00	49,927.00
LABORATORY-GENERAL	8,969,250.33	0.00
RADIOLOGY-DIAGNOSTIC	1,043,698.80	0.00
CT SCAN	1,521,354.00	4,408.40
PHYSICAL THERAPY	154,292.90	0.00
EKG/ECG	225,966.40	0.00
IV THERAPY	579.20	0.00
OPERATING ROOM	2,481,193.30	0.00
LABOR/DELIVERY ROOM	4,584,794.80	0.00
RESPIRATORY SERVICES	3,637,982.20	0.00
ANESTHESIA	1,020,098.80	0.00
GI SERVICES	146,653.10	0.00
EMERGENCY ROOM	811,903.00	0.00
RECOVERY ROOM	829,377.80	0.00
LABORATORY PATHOLOGIC	547,060.30	0.00
RADIOLOGY THERAPEUTIC	66,741.20	0.00
OCCUPATIONAL THERAPY	68,336.30	0.00
SPEECH PATHOLOGY	53,149.90	0.00
RENAL DIALYSIS	373,744.80	0.00
OUTPATIENT SERVICES	171.60	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	567,503.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	365,932.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	406,993.40	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	778,413.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	47,924.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,799.80	0.00
OTHER LAB SERVICES	172,082.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	882.00	0.00
OTHER THERAPEUTIC SERVI	0.00	409.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	491,351.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,524,862.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,687.20
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,264.00

TOTAL ANCILLARY	52,147,936.99	57,695.60
TOTAL ACCOMODATIONS	13,304,952.00	1,622,685.00
TOTAL CHARGES	65,452,888.99	1,680,380.60

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	113,354.70	ADJUSTMENTS	0.00
COVERED CHARGES	112,094.20	CONTRACTUAL ALLOW	20,900.65
NON-COVERED CHARGES	1,260.50	TOTAL MEDICAID LIAB	91,193.55
		LESS: COB	91,193.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	24	0	14,520.00	594.00
NURSERY CARE CHARGES	2	0	900.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	26	0	15,420.00	594.00
SPECIAL CARE SERVICES				
C C U	2	0	1,754.00	0.00
I C U	0	0	0.00	0.00
N I C U	2	0	3,358.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	5,112.00	0.00
TOTAL ACCOMODATIONS	30	0	20,532.00	594.00

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,177.40	0.00
MED/SURG SUPPLY	12,049.90	666.50
LABORATORY-GENERAL	14,749.50	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	273.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	28,381.00	0.00
RESPIRATORY SERVICES	363.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	911.00	0.00
RECOVERY ROOM	1,353.00	0.00
LABORATORY PATHOLOGIC	2,383.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	727.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,799.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,172.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,998.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	225.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	91,562.20	666.50
TOTAL ACCOMODATIONS	20,532.00	594.00
TOTAL CHARGES	112,094.20	1,260.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,326,934.44	ADJUSTMENTS	434,063.54
COVERED CHARGES	18,835,083.33	CONTRACTUAL ALLOW	12,875,435.42
NON-COVERED CHARGES	1,491,851.11	TOTAL MEDICAID LIAB	5,959,647.91
		LESS: COB	1,490.79
		LESS: COPAYMENT	10,860.00
		REIMBURSEMENT	5,947,297.12
		ALL OTHER	5,528,225.09
		FEE SCHEDULE-LAB	372,266.43
		INJECTABLE DRUGS	46,805.60

TOTAL NUMBER OF CLAIMS 15,255

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,499,384.64	42,881.75
MED/SURG SUPPLY	1,112,202.25	11,157.00
LABORATORY-GENERAL	3,128.00	356,011.80
RADIOLOGY-DIAGNOSTIC	1,407,776.90	23,535.00
CT SCAN	1,654,963.40	85,038.30
PHYSICAL THERAPY	177,077.80	5,399.90
EKG/ECG	183,847.00	2,508.00
IV THERAPY	22,912.00	0.00
OPERATING ROOM	1,254,246.84	118,072.56
LABOR/DELIVERY ROOM	2,587.80	0.00
RESPIRATORY SERVICES	74,847.40	3,066.70
ANESTHESIA	494,289.80	0.00
GI SERVICES	176,118.20	9,780.00
EMERGENCY ROOM	3,097,543.40	30,422.90
RECOVERY ROOM	222,804.80	728.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	136,328.40	6,709.20
OCCUPATIONAL THERAPY	86,519.70	2,181.20
SPEECH PATHOLOGY	105,354.40	364.00
RENAL DIALYSIS	0.00	4,303.20
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	17,008.40	171.60
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,124,607.40	32,519.60
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	997.50	6,273.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	198,247.00	2,569.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	159,539.60	2,494.80
AMBULATORY SURGERY	65,383.20	2,172.80
OSTEOPATHIC SERVICES	0.00	0.00
E E G	123,667.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	412,311.46	15,244.90
OTHER LAB SERVICES	136,606.00	0.00
RECREATIONAL THERAPY	1,959.60	0.00
EDUCATION & TRAINING	48,590.00	144.00
OTHER THERAPEUTIC SERVI	1,494.00	3,326.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,220,712.22	524,020.38
MRI SERVICES	463,984.00	8,250.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	147,720.02	184,124.22
HOME HEALTH SERVICES	0.00	1,722.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	12.10
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	323.00	4,931.00

TOTAL ANCILLARY	18,835,083.33	1,490,136.11
TOTAL ACCOMODATIONS	0.00	1,715.00
TOTAL CHARGES	18,835,083.33	1,491,851.11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	101,590.50	ADJUSTMENTS	0.00
COVERED CHARGES	82,155.80	CONTRACTUAL ALLOW	9,780.05
NON-COVERED CHARGES	19,434.70	TOTAL MEDICAID LIAB	72,375.75
		LESS: COB	72,345.75
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,246.37-
		FEE SCHEDULE-LAB	1,204.12
		INJECTABLE DRUGS	42.25

TOTAL NUMBER OF CLAIMS 60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,388.40	0.00
MED/SURG SUPPLY	5,503.00	659.00
LABORATORY-GENERAL	0.00	421.90
RADIOLOGY-DIAGNOSTIC	2,332.60	302.00
CT SCAN	13,722.00	13,508.00
PHYSICAL THERAPY	1,016.00	0.00
EKG/ECG	250.80	273.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,996.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,172.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,281.00	0.00
RECOVERY ROOM	1,144.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,229.10	0.00
SPEECH PATHOLOGY	9,225.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,157.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	417.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,791.60	0.00
OTHER LAB SERVICES	1,157.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	456.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,649.30	3,569.70
MRI SERVICES	3,117.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	150.20	251.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,155.80	18,984.70
TOTAL ACCOMODATIONS	0.00	450.00
TOTAL CHARGES	82,155.80	19,434.70

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,170,155.00	ADJUSTMENTS	2,549.00
COVERED CHARGES	1,143,691.80	CONTRACTUAL ALLOW	1,056,610.62
NON-COVERED CHARGES	26,463.20	TOTAL MEDICAID LIAB	87,081.18
		LESS: COB	0.00
		LESS: COPAYMENT	1,356.00
		REIMBURSEMENT	85,725.18

TOTAL NUMBER OF CLAIMS 1,710

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,022.50	0.00
MED/SURG SUPPLY	37,831.40	735.00
LABORATORY-GENERAL	230,854.10	16,017.50
RADIOLOGY-DIAGNOSTIC	77,770.60	0.00
CT SCAN	49,776.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	18,171.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,352.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,656.50	0.00
ANESTHESIA	848.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	538,656.90	1,967.90
RECOVERY ROOM	585.00	0.00
LABORATORY PATHOLOGIC	1,672.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	52,803.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,271.20	0.00
OTHER LAB SERVICES	11,335.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	98.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,063.00	1,373.00
MRI SERVICES	10,893.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,030.80	6,369.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,143,691.80	26,463.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,143,691.80	26,463.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,805.70	ADJUSTMENTS	0.00
COVERED CHARGES	4,444.40	CONTRACTUAL ALLOW	1,641.70
NON-COVERED CHARGES	361.30	TOTAL MEDICAID LIAB	2,802.70
		LESS: COB	2,799.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260.00	0.00
MED/SURG SUPPLY	154.00	0.00
LABORATORY-GENERAL	1,650.40	350.30
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	546.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,834.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	11.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,444.40	361.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,444.40	361.30

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,368,511.63	ADJUSTMENTS	196,615.01
COVERED CHARGES	5,120,354.37	CONTRACTUAL ALLOW	3,969,872.97
NON-COVERED CHARGES	248,157.26	TOTAL MEDICAID LIAB	1,150,481.40
		LESS: COB	0.00
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	1,149,677.40

TOTAL NUMBER OF CLAIMS 269

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	451,558.56	31,792.10
MED/SURG SUPPLY	670,106.80	23,527.00
LABORATORY-GENERAL	384.00	1,082.00
RADIOLOGY-DIAGNOSTIC	121,229.70	14,480.80
CT SCAN	107,098.00	0.00
PHYSICAL THERAPY	2,880.20	1,060.40
EKG/ECG	19,580.40	0.00
IV THERAPY	18,248.00	2,416.00
OPERATING ROOM	1,420,303.74	64,960.46
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	300.00	0.00
ANESTHESIA	548,087.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,968.00	0.00
RECOVERY ROOM	121,598.40	1,144.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	230,118.20	14,721.40
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,122.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,949.60	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,986.80	1,336.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	921.00	1,720.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,450.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	129,570.80	0.00
AMBULATORY SURGERY	35,534.40	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	89,567.10	4,468.00
OTHER LAB SERVICES	1,324.00	0.00
RECREATIONAL THERAPY	498.00	83.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	747.00	4,801.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	986,473.75	37,978.80
MRI SERVICES	28,647.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	82,223.72	41,463.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,120,354.37	248,157.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,120,354.37	248,157.26

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	79,191,353.03	ADJUSTMENTS	14,423,707.58
COVERED CHARGES	77,711,992.03	CONTRACTUAL ALLOW	50,387,847.13
NON-COVERED CHARGES	1,479,361.00	TOTAL MEDICAID LIAB	27,324,144.90
		LESS: COB	111,164.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,212,980.65

TOTAL NUMBER OF ADMISSIONS 4,128

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7,877	63	5,150,360.00	765,752.00
NURSERY CARE CHARGES	2,892	0	1,559,693.00	530,135.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	5	0.00	0.00
TOTAL ROUTINE	10,769	68	6,710,053.00	1,295,887.00
SPECIAL CARE SERVICES				
C C U	2,398	0	2,629,655.00	0.00
I C U	1,466	0	3,101,910.00	0.00
N I C U	2,185	0	4,169,336.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	90	0.00	78,531.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,049	90	9,900,901.00	78,531.00
TOTAL ACCOMODATIONS	16,818	158	16,610,954.00	1,374,418.00

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,337,665.29	1,771.00
MED/SURG SUPPLY	7,404,011.34	95,695.00
LABORATORY-GENERAL	10,462,190.40	0.00
RADIOLOGY-DIAGNOSTIC	1,360,091.00	0.00
CT SCAN	1,865,574.00	0.00
PHYSICAL THERAPY	237,653.00	0.00
EKG/ECG	225,027.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,254,482.00	0.00
LABOR/DELIVERY ROOM	4,876,279.00	0.00
RESPIRATORY SERVICES	3,987,466.00	0.00
ANESTHESIA	845,305.00	0.00
GI SERVICES	194,058.00	0.00
EMERGENCY ROOM	906,123.00	0.00
RECOVERY ROOM	1,028,872.00	0.00
LABORATORY PATHOLOGIC	652,361.00	0.00
RADIOLOGY THERAPEUTIC	58,316.00	0.00
OCCUPATIONAL THERAPY	159,303.00	0.00
SPEECH PATHOLOGY	117,803.00	0.00
RENAL DIALYSIS	356,826.00	0.00
OUTPATIENT SERVICES	331.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	875,750.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	543,895.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	444,785.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	894,389.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	84,853.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,146.00	0.00
OTHER LAB SERVICES	222,516.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,601.00	0.00
OTHER THERAPEUTIC SERVI	0.00	7,352.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	632,976.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,390.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	125.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	61,101,038.03	104,943.00
TOTAL ACCOMODATIONS	16,610,954.00	1,374,418.00
TOTAL CHARGES	77,711,992.03	1,479,361.00

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	602,297.17	ADJUSTMENTS	0.00
COVERED CHARGES	601,899.17	CONTRACTUAL ALLOW	564,308.44
NON-COVERED CHARGES	398.00	TOTAL MEDICAID LIAB	37,590.73
		LESS: COB	37,590.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7	0	4,451.00	398.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	4,451.00	398.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	65	0	148,265.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	65	0	148,265.00	0.00
TOTAL ACCOMODATIONS	72	0	152,716.00	398.00

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,583.17	0.00
MED/SURG SUPPLY	44,110.00	0.00
LABORATORY-GENERAL	4,465.00	0.00
RADIOLOGY-DIAGNOSTIC	400.00	0.00
CT SCAN	2,732.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,668.00	0.00
LABOR/DELIVERY ROOM	3,597.00	0.00
RESPIRATORY SERVICES	91,274.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,447.00	0.00
RECOVERY ROOM	806.00	0.00
LABORATORY PATHOLOGIC	1,381.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,720.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	449,183.17	0.00
TOTAL ACCOMODATIONS	152,716.00	398.00
TOTAL CHARGES	601,899.17	398.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	25,199,868.15	ADJUSTMENTS	704,457.92
COVERED CHARGES	23,525,297.79	CONTRACTUAL ALLOW	18,716,624.26
NON-COVERED CHARGES	1,674,570.36	TOTAL MEDICAID LIAB	4,808,673.53
		LESS: COB	607.18
		LESS: COPAYMENT	11,532.00
		REIMBURSEMENT	4,796,534.35
		ALL OTHER	4,313,747.64
		FEE SCHEDULE-LAB	431,173.52
		INJECTABLE DRUGS	51,613.19

TOTAL NUMBER OF CLAIMS 16,442

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,736,615.95	17,319.00
MED/SURG SUPPLY	1,368,913.71	39,334.25
LABORATORY-GENERAL	4,270.00	453,584.00
RADIOLOGY-DIAGNOSTIC	1,528,626.00	17,593.00
CT SCAN	1,902,547.00	182,743.00
PHYSICAL THERAPY	298,918.00	402.00
EKG/ECG	178,188.00	298.00
IV THERAPY	13,639.00	648.00
OPERATING ROOM	1,739,831.00	99,675.00
LABOR/DELIVERY ROOM	10,849.00	0.00
RESPIRATORY SERVICES	83,467.00	0.00
ANESTHESIA	667,641.00	0.00
GI SERVICES	185,489.00	862.00
EMERGENCY ROOM	3,296,740.00	20,061.00
RECOVERY ROOM	276,278.00	2,484.00
LABORATORY PATHOLOGIC	0.00	1,668.00
RADIOLOGY THERAPEUTIC	185,383.00	922.00
OCCUPATIONAL THERAPY	110,973.00	235.00
SPEECH PATHOLOGY	116,453.00	0.00
RENAL DIALYSIS	0.00	12,524.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,937.00	90.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,524,674.00	46,917.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,158.00	9,108.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	224,259.00	4,874.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	253,376.00	2,126.00
AMBULATORY SURGERY	77,476.50	362.50
OSTEOPATHIC SERVICES	0.00	0.00
E E G	318,783.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	619,135.00	13,758.00
OTHER LAB SERVICES	211,306.00	596.00
RECREATIONAL THERAPY	5,167.00	0.00
EDUCATION & TRAINING	52,881.00	265.00
OTHER THERAPEUTIC SERVI	249.00	2,520.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,572,055.30	595,066.80
MRI SERVICES	725,440.00	24,539.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	90.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	154.00
INJECTABLE DRUGS	211,734.33	116,015.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	755.00	590.00

TOTAL ANCILLARY	23,525,297.79	1,667,334.36
TOTAL ACCOMODATIONS	0.00	7,236.00
TOTAL CHARGES	23,525,297.79	1,674,570.36

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	49,610.00	ADJUSTMENTS	0.00
COVERED CHARGES	46,573.00	CONTRACTUAL ALLOW	18,628.30
NON-COVERED CHARGES	3,037.00	TOTAL MEDICAID LIAB	27,944.70
		LESS: COB	27,926.70
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	556.68-
		FEE SCHEDULE-LAB	547.43
		INJECTABLE DRUGS	9.25

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,375.00	0.00
MED/SURG SUPPLY	2,993.00	0.00
LABORATORY-GENERAL	0.00	408.00
RADIOLOGY-DIAGNOSTIC	1,020.00	0.00
CT SCAN	10,511.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	298.00	0.00
IV THERAPY	736.00	0.00
OPERATING ROOM	3,726.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,575.50	0.00
ANESTHESIA	1,359.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,779.00	0.00
RECOVERY ROOM	859.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,643.00	258.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,725.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,594.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	202.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,907.50	575.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,573.00	3,037.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,573.00	3,037.00

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,786,885.11	ADJUSTMENTS	3,779.76
COVERED CHARGES	1,705,298.11	CONTRACTUAL ALLOW	1,600,502.72
NON-COVERED CHARGES	81,587.00	TOTAL MEDICAID LIAB	104,795.39
		LESS: COB	0.00
		LESS: COPAYMENT	3,171.00
		REIMBURSEMENT	101,624.39

TOTAL NUMBER OF CLAIMS 2,055

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,870.49	65.00
MED/SURG SUPPLY	55,465.00	463.00
LABORATORY-GENERAL	414,832.00	23,415.00
RADIOLOGY-DIAGNOSTIC	98,078.00	0.00
CT SCAN	65,737.00	30,219.00
PHYSICAL THERAPY	320.00	0.00
EKG/ECG	13,118.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	65.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,946.00	0.00
ANESTHESIA	894.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	781,147.01	1,868.00
RECOVERY ROOM	439.00	0.00
LABORATORY PATHOLOGIC	2,410.00	170.00
RADIOLOGY THERAPEUTIC	14,845.00	643.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	60,389.00	8,688.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,738.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,567.00	0.00
OTHER LAB SERVICES	19,777.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,873.00	3,003.00
MRI SERVICES	6,067.00	3,660.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31,785.61	9,328.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,705,298.11	81,587.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,705,298.11	81,587.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,000.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,074.00	CONTRACTUAL ALLOW	12,095.02
NON-COVERED CHARGES	2,926.00	TOTAL MEDICAID LIAB	978.98
		LESS: COB	978.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,001.00	0.00
MED/SURG SUPPLY	691.00	0.00
LABORATORY-GENERAL	4,031.00	602.00
RADIOLOGY-DIAGNOSTIC	329.00	361.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,609.00	1,919.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,051.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	362.00	44.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,074.00	2,926.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,074.00	2,926.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,471,705.30	ADJUSTMENTS	234,197.89
COVERED CHARGES	4,310,168.16	CONTRACTUAL ALLOW	3,557,130.63
NON-COVERED CHARGES	161,537.14	TOTAL MEDICAID LIAB	753,037.53
		LESS: COB	0.00
		LESS: COPAYMENT	834.00
		REIMBURSEMENT	752,203.53

TOTAL NUMBER OF CLAIMS 201

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	461,085.54	2,461.00
MED/SURG SUPPLY	533,497.80	6,791.00
LABORATORY-GENERAL	699.00	2,994.00
RADIOLOGY-DIAGNOSTIC	86,759.00	3,889.00
CT SCAN	79,087.00	6,880.00
PHYSICAL THERAPY	5,009.00	595.00
EKG/ECG	24,527.00	0.00
IV THERAPY	5,671.00	0.00
OPERATING ROOM	1,393,345.84	36,753.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,148.00	0.00
ANESTHESIA	530,576.00	0.00
GI SERVICES	1,338.00	0.00
EMERGENCY ROOM	47,388.00	1,165.00
RECOVERY ROOM	110,517.00	0.00
LABORATORY PATHOLOGIC	0.00	3,925.00
RADIOLOGY THERAPEUTIC	135,032.00	920.00
OCCUPATIONAL THERAPY	192.00	0.00
SPEECH PATHOLOGY	712.00	0.00
RENAL DIALYSIS	0.00	2,593.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,313.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,738.00	1,334.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	921.00	684.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	52,854.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	67,063.00	235.00
AMBULATORY SURGERY	9,504.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	156,542.00	0.00
OTHER LAB SERVICES	9,010.00	0.00
RECREATIONAL THERAPY	1,585.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	581.00	865.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	515,535.58	48,307.80
MRI SERVICES	22,235.00	3,660.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,702.40	34,613.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,310,168.16	158,665.14
TOTAL ACCOMODATIONS	0.00	2,872.00
TOTAL CHARGES	4,310,168.16	161,537.14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	59,214,165.83	ADJUSTMENTS	13,929,011.93
COVERED CHARGES	58,822,798.83	CONTRACTUAL ALLOW	37,456,500.71
NON-COVERED CHARGES	391,367.00	TOTAL MEDICAID LIAB	21,366,298.12
		LESS: COB	105,475.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,260,822.65

TOTAL NUMBER OF ADMISSIONS 2,133

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,129	1	3,985,757.00	258,407.00
NURSERY CARE CHARGES	1,142	0	678,087.00	98,200.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	7	0.00	0.00
TOTAL ROUTINE	6,271	8	4,663,844.00	356,607.00
SPECIAL CARE SERVICES				
C C U	2,508	0	3,523,837.00	0.00
I C U	879	0	2,116,035.00	0.00
N I C U	962	0	2,061,890.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	22	0.00	21,090.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4,349	22	7,701,762.00	21,090.00
TOTAL ACCOMODATIONS	10,620	30	12,365,606.00	377,697.00

INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,534,828.93	396.00
MED/SURG SUPPLY	5,440,992.14	6,834.00
LABORATORY-GENERAL	8,221,565.48	0.00
RADIOLOGY-DIAGNOSTIC	1,014,318.00	0.00
CT SCAN	1,613,008.00	0.00
PHYSICAL THERAPY	137,877.00	0.00
EKG/ECG	204,973.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,643,029.00	0.00
LABOR/DELIVERY ROOM	2,136,688.00	0.00
RESPIRATORY SERVICES	3,442,170.00	0.00
ANESTHESIA	927,897.00	0.00
GI SERVICES	180,512.00	0.00
EMERGENCY ROOM	1,022,754.00	0.00
RECOVERY ROOM	660,628.00	0.00
LABORATORY PATHOLOGIC	378,642.00	0.00
RADIOLOGY THERAPEUTIC	71,455.00	0.00
OCCUPATIONAL THERAPY	88,212.00	0.00
SPEECH PATHOLOGY	74,153.00	0.00
RENAL DIALYSIS	502,105.00	0.00
OUTPATIENT SERVICES	228.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	608,853.00	0.00
BLOOD	379.00	0.00
BLOOD STORAGE & PRO.	616,182.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	417,701.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	853,915.00	0.00
AMBULATORY SURGERY	184.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	54,937.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	48,713.28	0.00
OTHER LAB SERVICES	170,401.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,247.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,111.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	386,389.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,256.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	75.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,254.00

TOTAL ANCILLARY	46,457,192.83	13,670.00
TOTAL ACCOMODATIONS	12,365,606.00	377,697.00
TOTAL CHARGES	58,822,798.83	391,367.00

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	427,555.40	ADJUSTMENTS	0.00
COVERED CHARGES	422,199.40	CONTRACTUAL ALLOW	361,153.60
NON-COVERED CHARGES	5,356.00	TOTAL MEDICAID LIAB	61,045.80
		LESS: COB	61,045.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	46	0	36,984.00	3,520.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	0	36,984.00	3,520.00
SPECIAL CARE SERVICES				
C C U	4	0	4,280.00	0.00
I C U	5	0	12,545.00	0.00
N I C U	5	0	10,250.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	27,075.00	0.00
TOTAL ACCOMODATIONS	60	0	64,059.00	3,520.00

ZERO PAID INPATIENT PAID CLAIMS

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,040.00	0.00
MED/SURG SUPPLY	34,944.40	1,836.00
LABORATORY-GENERAL	45,014.00	0.00
RADIOLOGY-DIAGNOSTIC	7,988.00	0.00
CT SCAN	12,509.00	0.00
PHYSICAL THERAPY	2,974.00	0.00
EKG/ECG	334.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	22,987.00	0.00
LABOR/DELIVERY ROOM	21,756.00	0.00
RESPIRATORY SERVICES	9,999.00	0.00
ANESTHESIA	9,933.00	0.00
GI SERVICES	1,464.00	0.00
EMERGENCY ROOM	1,967.00	0.00
RECOVERY ROOM	8,927.00	0.00
LABORATORY PATHOLOGIC	1,680.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,124.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	10,549.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,597.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,666.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,670.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,018.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	358,140.40	1,836.00
TOTAL ACCOMODATIONS	64,059.00	3,520.00
TOTAL CHARGES	422,199.40	5,356.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	14,003,997.98	ADJUSTMENTS	286,667.43
COVERED CHARGES	12,907,295.04	CONTRACTUAL ALLOW	10,688,023.59
NON-COVERED CHARGES	1,096,702.94	TOTAL MEDICAID LIAB	2,219,271.45
		LESS: COB	1,715.00
		LESS: COPAYMENT	6,114.00
		REIMBURSEMENT	2,211,442.45
		ALL OTHER	1,992,105.89
		FEE SCHEDULE-LAB	191,479.46
		INJECTABLE DRUGS	27,857.10

TOTAL NUMBER OF CLAIMS 5,603

OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	872,115.85	9,731.75
MED/SURG SUPPLY	778,807.42	56,799.85
LABORATORY-GENERAL	0.00	121,275.00
RADIOLOGY-DIAGNOSTIC	734,839.00	13,637.00
CT SCAN	1,240,413.00	189,140.00
PHYSICAL THERAPY	73,678.00	6,424.00
EKG/ECG	138,897.00	0.00
IV THERAPY	48,545.00	0.00
OPERATING ROOM	896,530.50	71,797.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	39,548.00	0.00
ANESTHESIA	351,755.00	0.00
GI SERVICES	182,345.00	10,801.00
EMERGENCY ROOM	1,991,936.00	2,033.00
RECOVERY ROOM	118,883.00	721.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	128,715.00	1,353.00
OCCUPATIONAL THERAPY	27,843.00	2,235.00
SPEECH PATHOLOGY	32,329.00	1,781.00
RENAL DIALYSIS	0.00	22,468.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	26,557.00	101.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	773,273.00	35,553.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,712.00	3,528.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	191,978.00	1,978.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	163,146.00	18,129.00
AMBULATORY SURGERY	75,184.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	113,769.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	343,446.84	0.00
OTHER LAB SERVICES	112,012.00	0.00
RECREATIONAL THERAPY	2,666.00	0.00
EDUCATION & TRAINING	4,016.00	59.00
OTHER THERAPEUTIC SERVI	2,765.00	4,472.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,864,194.67	420,594.12
MRI SERVICES	421,538.00	21,384.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	138,857.76	80,463.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	244.00

TOTAL ANCILLARY	12,907,295.04	1,096,702.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,907,295.04	1,096,702.94

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	50,517.58	ADJUSTMENTS	0.00
COVERED CHARGES	47,868.58	CONTRACTUAL ALLOW	25,619.23
NON-COVERED CHARGES	2,649.00	TOTAL MEDICAID LIAB	22,249.35
		LESS: COB	22,243.35
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	617.12-
		FEE SCHEDULE-LAB	617.92
		INJECTABLE DRUGS	0.80-

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,805.10	144.00
MED/SURG SUPPLY	2,338.00	0.00
LABORATORY-GENERAL	0.00	321.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	8,695.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,430.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,246.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,558.00	0.00
RECOVERY ROOM	860.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,698.00	831.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,458.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,782.00	576.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,987.48	691.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11.00	86.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	47,868.58	2,649.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,868.58	2,649.00

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	998,349.77	ADJUSTMENTS	1,613.44
COVERED CHARGES	966,706.05	CONTRACTUAL ALLOW	919,790.95
NON-COVERED CHARGES	31,643.72	TOTAL MEDICAID LIAB	46,915.10
		LESS: COB	0.00
		LESS: COPAYMENT	1,857.00
		REIMBURSEMENT	45,058.10

TOTAL NUMBER OF CLAIMS 933

OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,895.90	373.00
MED/SURG SUPPLY	30,787.00	329.00
LABORATORY-GENERAL	218,272.00	10,972.00
RADIOLOGY-DIAGNOSTIC	56,709.00	0.00
CT SCAN	42,648.00	14,031.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,810.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,009.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	646.00	0.00
ANESTHESIA	1,316.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	464,617.00	0.00
RECOVERY ROOM	924.00	0.00
LABORATORY PATHOLOGIC	1,668.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	169.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,523.00	3,324.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,401.00	0.00
OTHER LAB SERVICES	9,888.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,164.00	333.72
MRI SERVICES	14,449.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,810.15	2,281.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	966,706.05	31,643.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	966,706.05	31,643.72

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	5,331.10	ADJUSTMENTS	0.00
COVERED CHARGES	4,824.10	CONTRACTUAL ALLOW	3,659.10
NON-COVERED CHARGES	507.00	TOTAL MEDICAID LIAB	1,165.00
		LESS: COB	1,162.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	425.10	0.00
MED/SURG SUPPLY	218.00	0.00
LABORATORY-GENERAL	1,049.00	466.00
RADIOLOGY-DIAGNOSTIC	405.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,718.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.00	41.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,824.10	507.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,824.10	507.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	2,959,755.64	ADJUSTMENTS	36,556.50
COVERED CHARGES	2,838,596.84	CONTRACTUAL ALLOW	2,443,203.44
NON-COVERED CHARGES	121,158.80	TOTAL MEDICAID LIAB	395,393.40
		LESS: COB	0.00
		LESS: COPAYMENT	663.00
		REIMBURSEMENT	394,730.40

TOTAL NUMBER OF CLAIMS 108

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,221.67	195.00
MED/SURG SUPPLY	285,370.40	31,650.30
LABORATORY-GENERAL	0.00	1,032.00
RADIOLOGY-DIAGNOSTIC	33,426.00	3,268.00
CT SCAN	61,198.00	0.00
PHYSICAL THERAPY	456.00	1,004.00
EKG/ECG	23,269.00	0.00
IV THERAPY	17,125.00	140.00
OPERATING ROOM	784,070.17	11,489.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,070.00	0.00
ANESTHESIA	322,551.00	0.00
GI SERVICES	3,918.00	1,390.00
EMERGENCY ROOM	34,233.00	0.00
RECOVERY ROOM	57,810.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	212,924.00	1,584.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,420.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,671.00	2,089.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,616.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	51,921.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	55,336.00	0.00
AMBULATORY SURGERY	12,338.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,194.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,203.00	0.00
OTHER LAB SERVICES	8,264.00	0.00
RECREATIONAL THERAPY	1,919.00	0.00
EDUCATION & TRAINING	0.00	118.00
OTHER THERAPEUTIC SERVI	555.00	3,322.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	477,088.78	43,780.00
MRI SERVICES	63,858.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,570.82	20,097.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,838,596.84	121,158.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,838,596.84	121,158.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET SOUTH FULTON INC.
DBA SOUTH FULTON MEDICAL CTR
1170 CLEVELAND AVE
EAST POINT GA 30344-3615

PROVIDER NUMBER 000001713A
NUMBER OF BEDS 373
TITLE XVIII NO: HPH0126GA

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	32,673,678.88	ADJUSTMENTS	703,997.93
COVERED CHARGES	28,794,740.88	CONTRACTUAL ALLOW	13,593,918.40
NON-COVERED CHARGES	3,878,938.00	TOTAL MEDICAID LIAB	15,200,822.48
		LESS: COB	235,523.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,965,299.19

TOTAL NUMBER OF ADMISSIONS 4,389

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	12,691	0	5,126,745.00	3,545,554.00
NURSERY CARE CHARGES	2,512	0	905,501.00	63,789.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	105	0.00	0.00
TOTAL ROUTINE	15,203	105	6,032,246.00	3,609,343.00
SPECIAL CARE SERVICES				
C C U	191	0	187,371.00	0.00
I C U	866	0	850,077.00	0.00
N I C U	40	0	36,040.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	31	0.00	16,435.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,097	31	1,073,488.00	16,435.00
TOTAL ACCOMODATIONS	16,300	136	7,105,734.00	3,625,778.00

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,031,496.87	0.00
MED/SURG SUPPLY	3,447,995.18	15,741.25
LABORATORY-GENERAL	3,051,005.28	0.00
RADIOLOGY-DIAGNOSTIC	412,027.60	0.00
CT SCAN	745,669.00	336.00
PHYSICAL THERAPY	101,412.15	0.00
EKG/ECG	212,671.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,733,779.50	0.00
LABOR/DELIVERY ROOM	1,033,210.05	0.00
RESPIRATORY SERVICES	819,957.50	0.00
ANESTHESIA	183,381.50	0.00
GI SERVICES	6,514.50	0.00
EMERGENCY ROOM	290,090.50	0.00
RECOVERY ROOM	167,541.00	0.00
LABORATORY PATHOLOGIC	121,442.75	0.00
RADIOLOGY THERAPEUTIC	33,405.75	0.00
OCCUPATIONAL THERAPY	26,944.75	0.00
SPEECH PATHOLOGY	9,900.25	0.00
RENAL DIALYSIS	77,903.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	8,169.50
PSYCHIATRIC SERVICES	558,524.00	59,345.25
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	164,917.00	9,017.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	282,502.25	132,205.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	62,664.00	0.00
AUDIOLOGY	64,724.00	0.00
CARDIOLOGY	366,283.25	0.00
AMBULATORY SURGERY	26,959.25	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	25,958.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	258,403.50	0.00
OTHER LAB SERVICES	69,172.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,091.25	1,291.75
OTHER THERAPEUTIC SERVI	110,912.75	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	164,645.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	90.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	424.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,901.25	17,881.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,659.00

TOTAL ANCILLARY	21,689,006.88	253,160.00
TOTAL ACCOMODATIONS	7,105,734.00	3,625,778.00
TOTAL CHARGES	28,794,740.88	3,878,938.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	703,016.71	ADJUSTMENTS	0.00
COVERED CHARGES	661,421.46	CONTRACTUAL ALLOW	141,939.36
NON-COVERED CHARGES	41,595.25	TOTAL MEDICAID LIAB	519,482.10
		LESS: COB	519,482.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 101

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	248	0	99,640.00	35,001.00
NURSERY CARE CHARGES	57	0	21,110.00	1,976.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	305	0	120,750.00	36,977.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	22	0	21,582.00	0.00
N I C U	2	0	1,802.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	23,384.00	0.00
TOTAL ACCOMODATIONS	329	0	144,134.00	36,977.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,616.25	0.00
MED/SURG SUPPLY	100,981.63	355.00
LABORATORY-GENERAL	61,151.58	0.00
RADIOLOGY-DIAGNOSTIC	7,746.00	0.00
CT SCAN	17,011.00	0.00
PHYSICAL THERAPY	1,975.75	0.00
EKG/ECG	4,381.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	70,162.25	0.00
LABOR/DELIVERY ROOM	56,065.50	0.00
RESPIRATORY SERVICES	13,352.00	0.00
ANESTHESIA	3,883.75	0.00
GI SERVICES	270.00	0.00
EMERGENCY ROOM	4,417.50	0.00
RECOVERY ROOM	1,764.25	0.00
LABORATORY PATHOLOGIC	5,304.25	0.00
RADIOLOGY THERAPEUTIC	1,708.25	0.00
OCCUPATIONAL THERAPY	494.75	0.00
SPEECH PATHOLOGY	334.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	204.50
PSYCHIATRIC SERVICES	1,590.00	858.75
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,829.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,763.00	1,830.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	730.25	0.00
AUDIOLOGY	1,125.75	0.00
CARDIOLOGY	11,735.50	0.00
AMBULATORY SURGERY	525.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	607.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,702.25	0.00
OTHER LAB SERVICES	3,081.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	29.00	0.00
OTHER THERAPEUTIC SERVI	3,272.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,678.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	150.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	7.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,213.00

TOTAL ANCILLARY	517,287.46	4,618.25
TOTAL ACCOMODATIONS	144,134.00	36,977.00
TOTAL CHARGES	661,421.46	41,595.25

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,613,350.05	ADJUSTMENTS	159,524.51
COVERED CHARGES	18,272,490.33	CONTRACTUAL ALLOW	10,137,393.86
NON-COVERED CHARGES	1,340,859.72	TOTAL MEDICAID LIAB	8,135,096.47
		LESS: COB	14,605.81
		LESS: COPAYMENT	20,928.00
		REIMBURSEMENT	8,099,562.66
		ALL OTHER	7,592,489.69
		FEE SCHEDULE-LAB	507,072.97
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27,580

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,743,131.42	123,989.17
MED/SURG SUPPLY	1,358,514.76	30,539.50
LABORATORY-GENERAL	1,361.00	17,226.81
RADIOLOGY-DIAGNOSTIC	651,454.75	49,054.50
CT SCAN	1,186,452.00	24,761.00
PHYSICAL THERAPY	70,773.55	7,439.75
EKG/ECG	224,744.50	5,509.25
IV THERAPY	0.00	0.00
OPERATING ROOM	1,564,858.00	360,882.00
LABOR/DELIVERY ROOM	209,609.25	428.50
RESPIRATORY SERVICES	199,540.75	78,118.00
ANESTHESIA	415,735.25	1,566.25
GI SERVICES	8,281.00	0.00
EMERGENCY ROOM	1,135,329.75	13,376.50
RECOVERY ROOM	505,686.00	759.00
LABORATORY PATHOLOGIC	0.00	267.00
RADIOLOGY THERAPEUTIC	208,813.25	2,393.00
OCCUPATIONAL THERAPY	9,181.25	8,540.75
SPEECH PATHOLOGY	6,952.75	3,579.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	436,150.50	3,612.00
PSYCHIATRIC SERVICES	4,456,664.75	180,989.75
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	312,925.00	40,520.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,427.50	25,466.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	129,003.50	565.75
AUDIOLOGY	1,365.50	0.00
CARDIOLOGY	214,651.75	4,085.25
AMBULATORY SURGERY	16,988.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	72,147.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	761,683.95	3,205.50
OTHER LAB SERVICES	68,422.75	281.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,090.50	337.50
OTHER THERAPEUTIC SERVI	1,083.00	15.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,804,659.15	348,640.24
MRI SERVICES	457,434.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	158.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	231.75	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,063.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,141.50	870.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	619.25

TOTAL ANCILLARY	18,272,490.33	1,340,859.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,272,490.33	1,340,859.72

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	53,368.75	ADJUSTMENTS	0.00
COVERED CHARGES	42,404.00	CONTRACTUAL ALLOW	11,237.56
NON-COVERED CHARGES	10,964.75	TOTAL MEDICAID LIAB	31,166.44
		LESS: COB	31,118.44
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	741.81-
		FEE SCHEDULE-LAB	741.81
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,071.00	228.25
MED/SURG SUPPLY	10,031.75	0.00
LABORATORY-GENERAL	0.00	19.50
RADIOLOGY-DIAGNOSTIC	483.00	87.00
CT SCAN	887.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	96.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,602.00	8,514.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	223.50	0.00
ANESTHESIA	2,633.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	425.50	0.00
RECOVERY ROOM	3,333.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	120.00	0.00
PSYCHIATRIC SERVICES	7,900.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	740.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	816.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,780.25	506.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	215.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	654.00

TOTAL ANCILLARY	42,404.00	10,964.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,404.00	10,964.75

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	412,260.82	ADJUSTMENTS	735.00
COVERED CHARGES	400,287.37	CONTRACTUAL ALLOW	347,387.37
NON-COVERED CHARGES	11,973.45	TOTAL MEDICAID LIAB	52,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,185.00
		REIMBURSEMENT	51,715.00

TOTAL NUMBER OF CLAIMS 1,058

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
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PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,345.62	0.00
MED/SURG SUPPLY	20,255.25	0.00
LABORATORY-GENERAL	64,806.25	9,171.20
RADIOLOGY-DIAGNOSTIC	25,004.00	723.00
CT SCAN	44,328.00	887.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,927.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,309.00	0.00
LABOR/DELIVERY ROOM	1,770.00	0.00
RESPIRATORY SERVICES	1,922.00	0.00
ANESTHESIA	639.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	163,421.25	59.25
RECOVERY ROOM	537.00	0.00
LABORATORY PATHOLOGIC	470.25	30.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	96.00	45.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,137.00	203.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	692.25	783.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	607.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,964.00	0.00
OTHER LAB SERVICES	1,967.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	62.75	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25.50	71.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	400,287.37	11,973.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	400,287.37	11,973.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,088.50	ADJUSTMENTS	0.00
COVERED CHARGES	2,703.50	CONTRACTUAL ALLOW	2,363.48
NON-COVERED CHARGES	385.00	TOTAL MEDICAID LIAB	340.02
		LESS: COB	337.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303.50	0.00
MED/SURG SUPPLY	287.25	0.00
LABORATORY-GENERAL	786.50	229.00
RADIOLOGY-DIAGNOSTIC	211.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	193.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	921.75	156.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,703.50	385.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,703.50	385.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST

VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,900,675.35	ADJUSTMENTS	8,071.16
COVERED CHARGES	2,869,133.82	CONTRACTUAL ALLOW	2,161,200.91
NON-COVERED CHARGES	31,541.53	TOTAL MEDICAID LIAB	707,932.91
		LESS: COB	0.00
		LESS: COPAYMENT	444.00
		REIMBURSEMENT	707,488.91

TOTAL NUMBER OF CLAIMS 177

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,823,452.39	0.00
MED/SURG SUPPLY	237,153.58	775.00
LABORATORY-GENERAL	1,000.00	694.25
RADIOLOGY-DIAGNOSTIC	31,394.70	762.00
CT SCAN	54,828.00	0.00
PHYSICAL THERAPY	325.00	162.50
EKG/ECG	3,192.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	174,375.75	125.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	222.75	0.00
ANESTHESIA	13,380.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,371.25	0.00
RECOVERY ROOM	23,376.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	332,490.25	2,477.75
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	334.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	40,398.75	0.00
PSYCHIATRIC SERVICES	24,150.00	0.00
LITHOTRIPSY	11,441.75	0.00
OTHER IMAGING SERVICES	406.00	6,417.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,788.00	7,485.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,398.75	55.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,095.00	7,663.50
AMBULATORY SURGERY	7,692.50	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	303.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,079.50	430.00
OTHER LAB SERVICES	1,698.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,242.15	3,814.03
MRI SERVICES	8,877.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	284.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	60.75

TOTAL ANCILLARY	2,869,133.82	31,541.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,869,133.82	31,541.53

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	34,630,990.43	ADJUSTMENTS	2,212,530.62
COVERED CHARGES	31,104,986.25	CONTRACTUAL ALLOW	15,178,754.09
NON-COVERED CHARGES	3,526,004.18	TOTAL MEDICAID LIAB	15,926,232.16
		LESS: COB	246,917.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,679,314.80

TOTAL NUMBER OF ADMISSIONS 4,257

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	12,248	0	5,327,880.00	3,179,255.00
NURSERY CARE CHARGES	2,408	0	923,928.00	69,125.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	78	0.00	0.01
TOTAL ROUTINE	14,656	78	6,251,808.00	3,248,380.01
SPECIAL CARE SERVICES				
C C U	175	0	182,000.00	0.00
I C U	850	0	884,691.00	0.00
N I C U	56	0	53,480.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	38	0.00	21,166.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,081	38	1,120,171.00	21,166.00
TOTAL ACCOMODATIONS	15,737	116	7,371,979.00	3,269,546.01

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,203,616.33	0.00
MED/SURG SUPPLY	3,693,936.26	13,345.75
LABORATORY-GENERAL	3,223,141.31	0.00
RADIOLOGY-DIAGNOSTIC	430,827.25	0.00
CT SCAN	786,731.00	0.00
PHYSICAL THERAPY	89,699.75	0.00
EKG/ECG	181,462.75	0.00
IV THERAPY	218.25	0.00
OPERATING ROOM	1,496,273.75	0.00
LABOR/DELIVERY ROOM	834,268.75	0.00
RESPIRATORY SERVICES	1,134,847.75	0.00
ANESTHESIA	151,276.50	0.00
GI SERVICES	1,499.25	0.00
EMERGENCY ROOM	337,823.50	0.00
RECOVERY ROOM	142,735.75	0.00
LABORATORY PATHOLOGIC	136,114.75	0.00
RADIOLOGY THERAPEUTIC	45,856.00	0.00
OCCUPATIONAL THERAPY	26,413.25	0.00
SPEECH PATHOLOGY	13,398.25	0.00
RENAL DIALYSIS	116,548.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	9,396.00
PSYCHIATRIC SERVICES	556,648.25	24,490.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	165,818.00	6,372.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	274,659.75	130,277.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	47,793.50	0.00
AUDIOLOGY	66,859.00	0.00
CARDIOLOGY	359,148.25	0.00
AMBULATORY SURGERY	86,747.25	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,034.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	523,583.50	0.00
OTHER LAB SERVICES	63,861.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,675.25	0.00
OTHER THERAPEUTIC SERVI	169,239.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	224,787.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	130.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	424.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	106,463.35	348.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	71,674.50

TOTAL ANCILLARY	23,733,007.25	256,458.17
TOTAL ACCOMODATIONS	7,371,979.00	3,269,546.01
TOTAL CHARGES	31,104,986.25	3,526,004.18

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,214,527.95	ADJUSTMENTS	0.00
COVERED CHARGES	1,130,383.65	CONTRACTUAL ALLOW	248,096.97
NON-COVERED CHARGES	84,144.30	TOTAL MEDICAID LIAB	882,286.68
		LESS: COB	882,286.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 121

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	455	0	197,925.00	67,765.00
NURSERY CARE CHARGES	33	0	12,243.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	488	0	210,168.00	67,765.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	31	0	32,240.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	31	0	32,240.00	0.00
TOTAL ACCOMODATIONS	519	0	242,408.00	67,765.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364,763.25	0.00
MED/SURG SUPPLY	162,991.40	12,670.55
LABORATORY-GENERAL	92,619.75	0.00
RADIOLOGY-DIAGNOSTIC	9,188.75	0.00
CT SCAN	27,817.00	0.00
PHYSICAL THERAPY	9,464.25	0.00
EKG/ECG	4,125.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	61,678.50	0.00
LABOR/DELIVERY ROOM	48,004.25	0.00
RESPIRATORY SERVICES	21,908.25	0.00
ANESTHESIA	3,906.75	0.00
GI SERVICES	286.25	0.00
EMERGENCY ROOM	11,280.75	0.00
RECOVERY ROOM	3,299.25	0.00
LABORATORY PATHOLOGIC	5,261.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	1,771.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	106.25
PSYCHIATRIC SERVICES	5,820.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,464.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,788.00	3,104.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,249.50	0.00
AUDIOLOGY	882.00	0.00
CARDIOLOGY	8,358.00	0.00
AMBULATORY SURGERY	1,744.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	643.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,809.75	0.00
OTHER LAB SERVICES	2,025.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	447.75	0.00
OTHER THERAPEUTIC SERVI	4,013.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,336.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	15.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	483.50

TOTAL ANCILLARY	887,975.65	16,379.30
TOTAL ACCOMODATIONS	242,408.00	67,765.00
TOTAL CHARGES	1,130,383.65	84,144.30

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,316,389.96	ADJUSTMENTS	327,187.34
COVERED CHARGES	19,182,820.02	CONTRACTUAL ALLOW	11,645,444.35
NON-COVERED CHARGES	1,133,569.94	TOTAL MEDICAID LIAB	7,537,375.67
		LESS: COB	24,075.19
		LESS: COPAYMENT	15,888.00
		REIMBURSEMENT	7,497,412.48
		ALL OTHER	6,998,363.28
		FEE SCHEDULE-LAB	498,834.69
		INJECTABLE DRUGS	214.51

TOTAL NUMBER OF CLAIMS 27,271

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,730,828.46	101,116.04
MED/SURG SUPPLY	1,579,380.60	16,588.30
LABORATORY-GENERAL	4,253.25	55,920.35
RADIOLOGY-DIAGNOSTIC	634,665.00	22,968.25
CT SCAN	1,249,091.00	28,574.00
PHYSICAL THERAPY	115,061.50	0.00
EKG/ECG	157,098.75	102.75
IV THERAPY	1,764.00	0.00
OPERATING ROOM	1,481,215.25	409,532.25
LABOR/DELIVERY ROOM	316.25	0.00
RESPIRATORY SERVICES	212,112.25	47,694.00
ANESTHESIA	408,779.75	3,296.25
GI SERVICES	2,119.75	0.00
EMERGENCY ROOM	1,046,827.25	3,646.50
RECOVERY ROOM	536,839.00	3,289.00
LABORATORY PATHOLOGIC	0.00	116.00
RADIOLOGY THERAPEUTIC	220,145.00	4,684.00
OCCUPATIONAL THERAPY	0.00	209.00
SPEECH PATHOLOGY	2,017.50	126.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	458,447.75	2,087.00
PSYCHIATRIC SERVICES	5,174,442.75	49,727.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	292,928.50	50,393.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	60,095.00	45,499.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	103,865.00	1,481.25
AUDIOLOGY	126.00	0.00
CARDIOLOGY	193,524.25	3,483.00
AMBULATORY SURGERY	140,280.75	3,072.50
OSTEOPATHIC SERVICES	0.00	0.00
E E G	113,166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	857,494.75	3,446.50
OTHER LAB SERVICES	72,821.25	127.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,890.00	301.75
OTHER THERAPEUTIC SERVI	310.25	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,842,259.71	240,174.00
MRI SERVICES	478,174.75	3,617.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,968.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	510.75	2,062.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	30,233.25

TOTAL ANCILLARY	19,182,820.02	1,133,569.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,182,820.02	1,133,569.94

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	83,670.00	ADJUSTMENTS	0.00
COVERED CHARGES	69,045.25	CONTRACTUAL ALLOW	34,318.22
NON-COVERED CHARGES	14,624.75	TOTAL MEDICAID LIAB	34,727.03
		LESS: COB	34,700.03
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,377.28-
		FEE SCHEDULE-LAB	1,377.28
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,273.00	0.00
MED/SURG SUPPLY	6,826.00	0.00
LABORATORY-GENERAL	0.00	222.50
RADIOLOGY-DIAGNOSTIC	960.25	133.75
CT SCAN	1,774.00	0.00
PHYSICAL THERAPY	1,300.00	0.00
EKG/ECG	205.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,499.00	2,232.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	93.50	0.00
ANESTHESIA	1,605.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,850.50	0.00
RECOVERY ROOM	2,637.75	0.00
LABORATORY PATHOLOGIC	0.00	67.25
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	170.00	58.75
PSYCHIATRIC SERVICES	27,000.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	904.00	9,558.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	1,638.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,266.25	0.00
OTHER LAB SERVICES	127.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,094.00	653.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	820.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,698.00

TOTAL ANCILLARY	69,045.25	14,624.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,045.25	14,624.75

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	390,629.78	ADJUSTMENTS	1,770.00
COVERED CHARGES	376,144.93	CONTRACTUAL ALLOW	326,239.59
NON-COVERED CHARGES	14,484.85	TOTAL MEDICAID LIAB	49,905.34
		LESS: COB	23.05
		LESS: COPAYMENT	1,083.00
		REIMBURSEMENT	48,799.29

TOTAL NUMBER OF CLAIMS 998

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,488.03	0.00
MED/SURG SUPPLY	21,739.00	0.00
LABORATORY-GENERAL	67,486.40	7,177.35
RADIOLOGY-DIAGNOSTIC	18,922.75	103.00
CT SCAN	32,134.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,754.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	693.50	3,055.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,163.50	0.00
ANESTHESIA	336.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	143,603.50	693.00
RECOVERY ROOM	496.00	0.00
LABORATORY PATHOLOGIC	224.25	64.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	211.50	0.00
SPEECH PATHOLOGY	399.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	216.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,623.00	287.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,569.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	321.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,045.25	51.00
OTHER LAB SERVICES	3,179.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	266.75	0.00
MRI SERVICES	7,983.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	287.50	482.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,572.00

TOTAL ANCILLARY	376,144.93	14,484.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	376,144.93	14,484.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,666.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,633.50	CONTRACTUAL ALLOW	1,121.12
NON-COVERED CHARGES	33.25	TOTAL MEDICAID LIAB	512.38
		LESS: COB	506.38
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71.25	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	106.50	33.25
RADIOLOGY-DIAGNOSTIC	617.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	503.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	335.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,633.50	33.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,633.50	33.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST

VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,822,493.65	ADJUSTMENTS	8,074.16
COVERED CHARGES	2,788,785.40	CONTRACTUAL ALLOW	2,198,799.77
NON-COVERED CHARGES	33,708.25	TOTAL MEDICAID LIAB	589,985.63
		LESS: COB	0.00
		LESS: COPAYMENT	999.00
		REIMBURSEMENT	588,986.63

TOTAL NUMBER OF CLAIMS 151

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
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PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,750,449.94	620.25
MED/SURG SUPPLY	132,993.82	2,549.00
LABORATORY-GENERAL	2,691.00	144.00
RADIOLOGY-DIAGNOSTIC	26,587.75	707.75
CT SCAN	53,232.00	179.00
PHYSICAL THERAPY	224.75	0.00
EKG/ECG	2,839.75	0.00
IV THERAPY	848.00	0.00
OPERATING ROOM	90,638.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49,937.00	0.00
ANESTHESIA	8,535.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,850.75	0.00
RECOVERY ROOM	14,632.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	358,620.14	5,980.75
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	26,666.00	144.00
PSYCHIATRIC SERVICES	41,930.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,235.75	3,186.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,456.75	14,142.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,754.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,379.75	0.00
AMBULATORY SURGERY	57,636.25	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	321.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	75,589.75	160.75
OTHER LAB SERVICES	2,534.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	45.00	119.50
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,376.75	3,229.00
MRI SERVICES	16,751.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.25	81.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,464.50

TOTAL ANCILLARY	2,788,785.40	33,708.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,788,785.40	33,708.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	30,659,858.73	ADJUSTMENTS	1,204,672.40
COVERED CHARGES	27,442,547.96	CONTRACTUAL ALLOW	14,032,440.47
NON-COVERED CHARGES	3,217,310.77	TOTAL MEDICAID LIAB	13,410,107.49
		LESS: COB	159,614.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,250,492.71

TOTAL NUMBER OF ADMISSIONS 3,853

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10,279	0	4,555,750.00	2,914,805.00
NURSERY CARE CHARGES	2,125	0	859,135.00	64,910.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	70	0.00	0.02
TOTAL ROUTINE	12,404	70	5,414,885.00	2,979,715.02
SPECIAL CARE SERVICES				
C C U	183	0	205,875.00	0.00
I C U	730	0	820,215.00	0.00
N I C U	23	0	23,230.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	13	0.00	7,670.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	936	13	1,049,320.00	7,670.00
TOTAL ACCOMODATIONS	13,340	83	6,464,205.00	2,987,385.02

INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,444,405.22	0.00
MED/SURG SUPPLY	2,815,677.74	2,475.00
LABORATORY-GENERAL	2,953,307.25	0.00
RADIOLOGY-DIAGNOSTIC	356,310.75	0.00
CT SCAN	855,957.25	0.00
PHYSICAL THERAPY	82,077.75	0.00
EKG/ECG	177,970.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,220,748.00	0.00
LABOR/DELIVERY ROOM	797,542.25	0.00
RESPIRATORY SERVICES	944,102.00	0.00
ANESTHESIA	118,072.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	393,767.50	0.00
RECOVERY ROOM	125,031.50	0.00
LABORATORY PATHOLOGIC	130,315.25	0.00
RADIOLOGY THERAPEUTIC	28,148.25	0.00
OCCUPATIONAL THERAPY	16,175.75	0.00
SPEECH PATHOLOGY	14,297.25	0.00
RENAL DIALYSIS	52,229.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	8,242.75
PSYCHIATRIC SERVICES	507,279.75	26,370.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	162,584.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	260,299.50	122,123.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,813.50	0.00
AUDIOLOGY	64,796.00	0.00
CARDIOLOGY	338,033.00	0.00
AMBULATORY SURGERY	93,132.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	26,710.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	436,511.25	0.00
OTHER LAB SERVICES	72,202.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	15,719.00	0.00
OTHER THERAPEUTIC SERVI	30,651.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	175,220.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	677.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	424.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	213,253.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,401.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	68,211.75

TOTAL ANCILLARY	20,978,342.96	229,925.75
TOTAL ACCOMODATIONS	6,464,205.00	2,987,385.02
TOTAL CHARGES	27,442,547.96	3,217,310.77

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	875,959.22	ADJUSTMENTS	0.00
COVERED CHARGES	836,538.72	CONTRACTUAL ALLOW	201,602.86
NON-COVERED CHARGES	39,420.50	TOTAL MEDICAID LIAB	634,935.86
		LESS: COB	634,935.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 132

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	290	0	127,865.00	35,865.00
NURSERY CARE CHARGES	56	0	22,265.00	540.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	346	0	150,130.00	36,405.00
SPECIAL CARE SERVICES				
C C U	6	0	6,750.00	0.00
I C U	19	0	21,160.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	25	0	27,910.00	0.00
TOTAL ACCOMODATIONS	371	0	178,040.00	36,405.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	198,589.80	0.00
MED/SURG SUPPLY	112,997.42	235.75
LABORATORY-GENERAL	72,447.25	0.00
RADIOLOGY-DIAGNOSTIC	8,057.00	0.00
CT SCAN	21,857.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,123.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	96,030.00	0.00
LABOR/DELIVERY ROOM	59,740.00	0.00
RESPIRATORY SERVICES	10,525.25	0.00
ANESTHESIA	6,091.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,437.00	0.00
RECOVERY ROOM	4,335.00	0.00
LABORATORY PATHOLOGIC	7,285.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	109.00
PSYCHIATRIC SERVICES	3,371.25	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,736.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,838.75	1,957.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	821.50	0.00
AUDIOLOGY	1,477.50	0.00
CARDIOLOGY	12,944.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,074.75	0.00
OTHER LAB SERVICES	911.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	85.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,586.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	280.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,135.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	57.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	376.00

TOTAL ANCILLARY	658,498.72	3,015.50
TOTAL ACCOMODATIONS	178,040.00	36,405.00
TOTAL CHARGES	836,538.72	39,420.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,162,748.52	ADJUSTMENTS	216,295.38
COVERED CHARGES	18,301,763.77	CONTRACTUAL ALLOW	12,587,300.34
NON-COVERED CHARGES	860,984.75	TOTAL MEDICAID LIAB	5,714,463.43
		LESS: COB	4,387.35
		LESS: COPAYMENT	18,051.00
		REIMBURSEMENT	5,692,025.08
		ALL OTHER	5,259,315.01
		FEE SCHEDULE-LAB	432,568.10
		INJECTABLE DRUGS	141.97

TOTAL NUMBER OF CLAIMS 24,832

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,209,387.79	4,862.50
MED/SURG SUPPLY	1,283,145.16	19,758.97
LABORATORY-GENERAL	0.00	53,669.50
RADIOLOGY-DIAGNOSTIC	562,672.25	31,230.00
CT SCAN	1,047,501.50	122,691.00
PHYSICAL THERAPY	218,192.25	247.00
EKG/ECG	131,081.50	436.00
IV THERAPY	0.00	112.50
OPERATING ROOM	1,690,095.75	178,875.00
LABOR/DELIVERY ROOM	155.50	0.00
RESPIRATORY SERVICES	289,358.75	19,048.50
ANESTHESIA	351,882.50	3,043.25
GI SERVICES	679.00	0.00
EMERGENCY ROOM	1,144,554.50	17,724.00
RECOVERY ROOM	477,911.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	189,336.25	22,966.25
OCCUPATIONAL THERAPY	113.50	0.00
SPEECH PATHOLOGY	4,558.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	481,207.00	5,230.50
PSYCHIATRIC SERVICES	4,582,612.75	6,625.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	272,585.75	38,286.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	35,698.25	32,348.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	98,370.50	1,575.00
AUDIOLOGY	134.00	0.00
CARDIOLOGY	178,089.10	5,537.75
AMBULATORY SURGERY	162,460.75	2,439.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	89,140.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	795,462.50	40,985.50
OTHER LAB SERVICES	83,369.75	575.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,413.50	739.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,698,601.72	191,210.78
MRI SERVICES	218,028.25	40,928.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	462.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	696.00
FREE STANDING CLINIC	520.25	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	443.00	3,134.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,087.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	14,460.00

TOTAL ANCILLARY	18,301,763.77	860,984.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,301,763.77	860,984.75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	90,334.40	ADJUSTMENTS	0.00
COVERED CHARGES	77,624.65	CONTRACTUAL ALLOW	53,149.70
NON-COVERED CHARGES	12,709.75	TOTAL MEDICAID LIAB	24,474.95
		LESS: COB	24,438.95
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,093.56-
		FEE SCHEDULE-LAB	2,093.56
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,142.75	0.00
MED/SURG SUPPLY	2,264.50	0.00
LABORATORY-GENERAL	0.00	393.75
RADIOLOGY-DIAGNOSTIC	3,415.00	149.50
CT SCAN	9,855.00	7,222.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	327.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,675.00	1,200.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	374.00	0.00
ANESTHESIA	1,071.00	357.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,834.25	67.00
RECOVERY ROOM	1,847.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	817.25
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	568.50	0.00
PSYCHIATRIC SERVICES	1,560.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,640.50	1,575.50
OTHER LAB SERVICES	689.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36,333.90	798.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	49.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	27.25	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	80.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	77,624.65	12,709.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,624.65	12,709.75

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	489,536.22	ADJUSTMENTS	1,264.00
COVERED CHARGES	477,480.22	CONTRACTUAL ALLOW	413,080.22
NON-COVERED CHARGES	12,056.00	TOTAL MEDICAID LIAB	64,400.00
		LESS: COB	20.22
		LESS: COPAYMENT	1,479.00
		REIMBURSEMENT	62,900.78

TOTAL NUMBER OF CLAIMS 1,288

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,047.22	0.00
MED/SURG SUPPLY	14,085.50	0.00
LABORATORY-GENERAL	82,022.00	5,706.00
RADIOLOGY-DIAGNOSTIC	17,945.25	109.25
CT SCAN	25,759.00	3,689.00
PHYSICAL THERAPY	55.50	0.00
EKG/ECG	5,014.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,075.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,500.00	0.00
ANESTHESIA	604.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	230,004.50	1,310.00
RECOVERY ROOM	815.00	0.00
LABORATORY PATHOLOGIC	71.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	532.25	27.00
PSYCHIATRIC SERVICES	212.00	159.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,580.25	304.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	159.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	341.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,705.50	237.00
OTHER LAB SERVICES	1,097.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,687.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	325.00	355.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	477,480.22	12,056.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	477,480.22	12,056.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	31,945.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,408.50	CONTRACTUAL ALLOW	25,896.49
NON-COVERED CHARGES	5,537.00	TOTAL MEDICAID LIAB	512.01
		LESS: COB	509.01
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
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NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,347.25	0.00
MED/SURG SUPPLY	832.00	0.00
LABORATORY-GENERAL	1,643.50	0.00
RADIOLOGY-DIAGNOSTIC	347.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,068.00	1,393.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	1,844.50
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	355.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	1,751.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,815.00	548.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,408.50	5,537.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,408.50	5,537.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST

VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,311,971.88	ADJUSTMENTS	6,899.04
COVERED CHARGES	3,172,472.63	CONTRACTUAL ALLOW	2,611,407.14
NON-COVERED CHARGES	139,499.25	TOTAL MEDICAID LIAB	561,065.49
		LESS: COB	0.00
		LESS: COPAYMENT	2,385.00
		REIMBURSEMENT	558,680.49

TOTAL NUMBER OF CLAIMS 162

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
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NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,991,334.79	0.00
MED/SURG SUPPLY	95,352.76	13,190.00
LABORATORY-GENERAL	0.00	229.00
RADIOLOGY-DIAGNOSTIC	33,866.00	3,673.75
CT SCAN	50,862.00	4,053.00
PHYSICAL THERAPY	238.75	0.00
EKG/ECG	763.00	0.00
IV THERAPY	0.00	330.00
OPERATING ROOM	49,400.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	145,584.00	0.00
ANESTHESIA	4,794.00	383.75
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,552.50	979.00
RECOVERY ROOM	14,064.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	271,538.75	54,127.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	16,327.75	8,917.50
PSYCHIATRIC SERVICES	33,040.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,623.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,387.25	8,778.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	781.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,496.00	11.75
AMBULATORY SURGERY	983.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	147,345.25	37,027.25
OTHER LAB SERVICES	298.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	144.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	293,055.83	1,610.50
MRI SERVICES	4,760.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.00	5,975.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	68.50

TOTAL ANCILLARY	3,172,472.63	139,499.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,172,472.63	139,499.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
TITLE XVIII NO: 1306896253

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,346.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,346.00	CONTRACTUAL ALLOW	10,815.86
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	8,530.14
		LESS: COB	8,524.14
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GA MED CTR
2501 NORTH PATTERSON ST
VALDOSTA GA 31602-1735

PROVIDER NUMBER 000001724A
NUMBER OF BEDS 288
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 1306896253

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,596.50	0.00
MED/SURG SUPPLY	141.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	918.50	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	312.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	231.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	145.50	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	19,346.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,346.00	0.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	28,495,441.95	ADJUSTMENTS	1,610,887.90
COVERED CHARGES	27,736,641.74	CONTRACTUAL ALLOW	15,753,698.14
NON-COVERED CHARGES	758,800.21	TOTAL MEDICAID LIAB	11,982,943.60
		LESS: COB	15,218.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,967,725.38

TOTAL NUMBER OF ADMISSIONS 2,970

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,438	19	3,874,220.00	566,857.00
NURSERY CARE CHARGES	2,034	0	1,187,505.60	19,026.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	39	0.00	0.00
TOTAL ROUTINE	8,472	58	5,061,725.60	585,883.00
SPECIAL CARE SERVICES				
C C U	390	0	504,236.00	0.00
I C U	1,917	0	2,077,100.00	0.00
N I C U	260	0	277,925.05	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,567	0	2,859,261.05	0.00
TOTAL ACCOMODATIONS	11,039	58	7,920,986.65	585,883.00

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,837,275.03	0.00
MED/SURG SUPPLY	1,181,609.64	8,404.50
LABORATORY-GENERAL	2,585,053.15	0.00
RADIOLOGY-DIAGNOSTIC	483,685.64	0.00
CT SCAN	741,249.43	4,883.00
PHYSICAL THERAPY	71,141.95	0.00
EKG/ECG	70,266.50	0.00
IV THERAPY	95,675.00	0.00
OPERATING ROOM	2,605,851.91	0.00
LABOR/DELIVERY ROOM	986,456.25	0.00
RESPIRATORY SERVICES	1,069,137.99	0.00
ANESTHESIA	538,026.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	297,076.18	0.00
RECOVERY ROOM	269,140.20	0.00
LABORATORY PATHOLOGIC	86,627.45	0.00
RADIOLOGY THERAPEUTIC	99,288.07	0.00
OCCUPATIONAL THERAPY	25,985.90	0.00
SPEECH PATHOLOGY	10,858.52	0.00
RENAL DIALYSIS	1,828.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,392.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	84,942.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	332,546.82	118,943.94
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	108,077.46	0.00
AUDIOLOGY	6,371.00	16,860.00
CARDIOLOGY	545,016.48	0.00
AMBULATORY SURGERY	51,769.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,032.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	326,248.13	0.00
OTHER LAB SERVICES	68,236.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	37.00
OTHER THERAPEUTIC SERVI	0.00	5,102.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	176,009.02	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	11,475.55	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,696.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16,294.77

TOTAL ANCILLARY	19,815,655.09	172,917.21
TOTAL ACCOMODATIONS	7,920,986.65	585,883.00
TOTAL CHARGES	27,736,641.74	758,800.21

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	31,812.14	ADJUSTMENTS	0.00
COVERED CHARGES	30,552.14	CONTRACTUAL ALLOW	7,556.88
NON-COVERED CHARGES	1,260.00	TOTAL MEDICAID LIAB	22,995.26
		LESS: COB	22,995.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7	0	4,081.00	1,084.00
NURSERY CARE CHARGES	8	0	4,664.00	56.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	8,745.00	1,140.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	8,745.00	1,140.00

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,610.63	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	1,796.25	0.00
RADIOLOGY-DIAGNOSTIC	824.00	0.00
CT SCAN	2,671.00	0.00
PHYSICAL THERAPY	165.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,794.00	0.00
LABOR/DELIVERY ROOM	4,347.00	0.00
RESPIRATORY SERVICES	29.00	0.00
ANESTHESIA	1,311.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	396.00	0.00
RECOVERY ROOM	748.00	0.00
LABORATORY PATHOLOGIC	161.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	60.00	120.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	894.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,807.14	120.00
TOTAL ACCOMODATIONS	8,745.00	1,140.00
TOTAL CHARGES	30,552.14	1,260.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,096,245.22	ADJUSTMENTS	51,529.14
COVERED CHARGES	10,439,920.84	CONTRACTUAL ALLOW	4,871,712.38
NON-COVERED CHARGES	656,324.38	TOTAL MEDICAID LIAB	5,568,208.46
		LESS: COB	13,036.03
		LESS: COPAYMENT	14,541.00
		REIMBURSEMENT	5,540,631.43
		ALL OTHER	5,327,254.20
		FEE SCHEDULE-LAB	213,349.19
		INJECTABLE DRUGS	28.04

TOTAL NUMBER OF CLAIMS 15,619

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,155,246.86	11,474.42
MED/SURG SUPPLY	153,501.82	275.00
LABORATORY-GENERAL	0.00	11,627.61
RADIOLOGY-DIAGNOSTIC	742,054.09	28,868.00
CT SCAN	955,248.42	51,789.24
PHYSICAL THERAPY	166,122.76	17,159.06
EKG/ECG	45,729.80	376.00
IV THERAPY	59,355.00	0.00
OPERATING ROOM	964,716.06	204,739.44
LABOR/DELIVERY ROOM	17,657.00	0.00
RESPIRATORY SERVICES	143,690.84	1,564.00
ANESTHESIA	289,026.00	459.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,997,375.09	12,406.20
RECOVERY ROOM	288,547.80	591.00
LABORATORY PATHOLOGIC	0.00	572.99
RADIOLOGY THERAPEUTIC	462,741.90	46,941.60
OCCUPATIONAL THERAPY	69,976.72	5,812.00
SPEECH PATHOLOGY	67,628.93	4,275.00
RENAL DIALYSIS	0.00	374.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,871.00	138.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	377,388.09	26,952.08
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,239.00	29,410.96
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	126,352.51	7,214.94
AUDIOLOGY	0.00	0.00
CARDIOLOGY	197,119.97	7,636.00
AMBULATORY SURGERY	91,733.00	5,776.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,691.16	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	428,463.00	6,634.00
OTHER LAB SERVICES	141,568.14	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	880.00	0.00
OTHER THERAPEUTIC SERVI	230.30	3,654.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,011,334.49	160,364.34
MRI SERVICES	424,350.84	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	8,646.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	378.00	314.00

TOTAL ANCILLARY	10,439,920.84	647,399.38
TOTAL ACCOMODATIONS	0.00	8,925.00
TOTAL CHARGES	10,439,920.84	656,324.38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	15,086.21	ADJUSTMENTS	0.00
COVERED CHARGES	13,514.79	CONTRACTUAL ALLOW	5,063.73
NON-COVERED CHARGES	1,571.42	TOTAL MEDICAID LIAB	8,451.06
		LESS: COB	8,436.06
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	837.52-
		FEE SCHEDULE-LAB	837.52
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	537.20	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	191.00
RADIOLOGY-DIAGNOSTIC	499.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	400.00	0.00
EKG/ECG	178.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,593.80	199.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	150.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	208.56	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	74.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	521.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	618.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,778.23	1,107.42
MRI SERVICES	2,013.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,514.79	1,571.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,514.79	1,571.42

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	409,544.20	ADJUSTMENTS	597.00
COVERED CHARGES	405,399.85	CONTRACTUAL ALLOW	321,199.85
NON-COVERED CHARGES	4,144.35	TOTAL MEDICAID LIAB	84,200.00
		LESS: COB	214.21
		LESS: COPAYMENT	1,749.00
		REIMBURSEMENT	82,236.79

TOTAL NUMBER OF CLAIMS 1,684

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,637.56	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	41,506.07	3,185.35
RADIOLOGY-DIAGNOSTIC	19,918.82	489.00
CT SCAN	18,776.84	0.00
PHYSICAL THERAPY	130.00	0.00
EKG/ECG	1,567.48	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,805.82	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	272,524.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,054.16	399.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	345.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	518.00	0.00
OTHER LAB SERVICES	465.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	71.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,099.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	51.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	405,399.85	4,144.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	405,399.85	4,144.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,861.71	ADJUSTMENTS	0.00
COVERED CHARGES	6,839.07	CONTRACTUAL ALLOW	5,809.39
NON-COVERED CHARGES	1,022.64	TOTAL MEDICAID LIAB	1,029.68
		LESS: COB	1,023.68
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,089.59	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	1,973.52	0.00
RADIOLOGY-DIAGNOSTIC	150.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	83.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,334.40	1,022.64
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	208.56	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,839.07	1,022.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,839.07	1,022.64

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE

BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,337,339.62	ADJUSTMENTS	12,348.86
COVERED CHARGES	2,257,150.88	CONTRACTUAL ALLOW	1,517,427.77
NON-COVERED CHARGES	80,188.74	TOTAL MEDICAID LIAB	739,723.11
		LESS: COB	135.49
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	739,299.62

TOTAL NUMBER OF CLAIMS 178

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	853,944.09	2,336.55
MED/SURG SUPPLY	130,852.10	0.00
LABORATORY-GENERAL	0.00	177.49
RADIOLOGY-DIAGNOSTIC	55,292.32	2,248.24
CT SCAN	28,562.24	4,564.00
PHYSICAL THERAPY	207.00	0.00
EKG/ECG	3,492.44	0.00
IV THERAPY	570.00	0.00
OPERATING ROOM	527,830.66	8,085.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,563.90	0.00
ANESTHESIA	104,070.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,455.00	0.00
RECOVERY ROOM	48,172.70	548.10
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	253,522.55	45,858.20
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	750.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	414.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	72,036.00	0.00
OTHER IMAGING SERVICES	2,817.86	428.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,750.00	2,788.58
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,345.68	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	49,717.84	0.00
AMBULATORY SURGERY	950.00	969.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	686.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	41,234.00	2,009.00
OTHER LAB SERVICES	931.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	4,454.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36,099.70	3,796.58
MRI SERVICES	14,597.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	36.80	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,176.00

TOTAL ANCILLARY	2,257,150.88	80,188.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,257,150.88	80,188.74

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	39,468.35	ADJUSTMENTS	0.00
COVERED CHARGES	39,468.35	CONTRACTUAL ALLOW	29,465.35
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	10,003.00
		LESS: COB	10,000.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,998.35	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,470.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	39,468.35	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,468.35	0.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	30,060,701.46	ADJUSTMENTS	2,657,852.59
COVERED CHARGES	29,537,585.65	CONTRACTUAL ALLOW	17,114,875.68
NON-COVERED CHARGES	523,115.81	TOTAL MEDICAID LIAB	12,422,709.97
		LESS: COB	36,793.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,385,916.39

TOTAL NUMBER OF ADMISSIONS 2,739

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,477	0	3,674,488.00	377,036.00
NURSERY CARE CHARGES	1,971	0	1,235,058.00	11,866.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	33	0.00	0.00
TOTAL ROUTINE	7,448	33	4,909,546.00	388,902.00
SPECIAL CARE SERVICES				
C C U	640	0	883,424.00	0.00
I C U	1,903	0	2,157,468.00	0.00
N I C U	186	0	211,074.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,729	0	3,251,966.00	0.00
TOTAL ACCOMODATIONS	10,177	33	8,161,512.00	388,902.00

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,674,857.37	0.00
MED/SURG SUPPLY	1,324,849.53	7,452.18
LABORATORY-GENERAL	2,737,629.43	1,323.00
RADIOLOGY-DIAGNOSTIC	424,334.75	0.00
CT SCAN	765,555.00	0.00
PHYSICAL THERAPY	80,300.91	0.00
EKG/ECG	88,126.25	0.00
IV THERAPY	264,334.96	0.00
OPERATING ROOM	2,427,565.61	0.00
LABOR/DELIVERY ROOM	998,313.50	0.00
RESPIRATORY SERVICES	1,134,903.27	0.00
ANESTHESIA	497,272.76	0.00
GI SERVICES	32,538.00	0.00
EMERGENCY ROOM	286,193.00	0.00
RECOVERY ROOM	271,403.29	0.00
LABORATORY PATHOLOGIC	77,744.00	0.00
RADIOLOGY THERAPEUTIC	78,749.75	0.00
OCCUPATIONAL THERAPY	27,270.70	0.00
SPEECH PATHOLOGY	11,292.47	0.00
RENAL DIALYSIS	7,626.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	101,522.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	442,326.64	112,593.27
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	126,431.60	0.00
AUDIOLOGY	55,344.73	0.00
CARDIOLOGY	626,161.45	0.00
AMBULATORY SURGERY	13,584.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,897.98	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	390,108.75	0.00
OTHER LAB SERVICES	111,051.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,789.11
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	241,587.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	3,981.25	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31,214.85	0.00
HOME HEALTH SERVICES	0.00	383.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	9,672.75

TOTAL ANCILLARY	21,376,073.65	134,213.81
TOTAL ACCOMODATIONS	8,161,512.00	388,902.00
TOTAL CHARGES	29,537,585.65	523,115.81

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	111,399.98	ADJUSTMENTS	0.00
COVERED CHARGES	110,110.98	CONTRACTUAL ALLOW	13,116.00
NON-COVERED CHARGES	1,289.00	TOTAL MEDICAID LIAB	96,994.98
		LESS: COB	96,994.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	31	0	20,632.00	1,289.00
NURSERY CARE CHARGES	6	0	3,616.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	37	0	24,248.00	1,289.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	37	0	24,248.00	1,289.00

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,874.79	0.00
MED/SURG SUPPLY	14,982.94	0.00
LABORATORY-GENERAL	6,464.50	0.00
RADIOLOGY-DIAGNOSTIC	2,241.00	0.00
CT SCAN	4,558.00	0.00
PHYSICAL THERAPY	532.25	0.00
EKG/ECG	0.00	0.00
IV THERAPY	202.25	0.00
OPERATING ROOM	21,726.00	0.00
LABOR/DELIVERY ROOM	156.50	0.00
RESPIRATORY SERVICES	3,936.75	0.00
ANESTHESIA	4,590.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	351.25	0.00
RECOVERY ROOM	1,994.00	0.00
LABORATORY PATHOLOGIC	689.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	280.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	981.00	0.00
AUDIOLOGY	192.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	110.75	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	85,862.98	0.00
TOTAL ACCOMODATIONS	24,248.00	1,289.00
TOTAL CHARGES	110,110.98	1,289.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,405,416.71	ADJUSTMENTS	161,355.55
COVERED CHARGES	12,850,814.86	CONTRACTUAL ALLOW	7,656,019.82
NON-COVERED CHARGES	554,601.85	TOTAL MEDICAID LIAB	5,194,795.04
		LESS: COB	6,736.35
		LESS: COPAYMENT	9,906.00
		REIMBURSEMENT	5,178,152.69
		ALL OTHER	4,940,155.51
		FEE SCHEDULE-LAB	237,899.09
		INJECTABLE DRUGS	98.09

TOTAL NUMBER OF CLAIMS 16,316

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,699,114.40	2,432.21
MED/SURG SUPPLY	468,466.06	7,206.13
LABORATORY-GENERAL	393.00	18,265.74
RADIOLOGY-DIAGNOSTIC	777,148.30	28,949.25
CT SCAN	996,730.25	28,403.00
PHYSICAL THERAPY	220,579.75	2,120.00
EKG/ECG	51,833.25	189.50
IV THERAPY	73,524.25	0.00
OPERATING ROOM	1,490,096.48	137,718.75
LABOR/DELIVERY ROOM	17,693.25	0.00
RESPIRATORY SERVICES	174,532.16	100.25
ANESTHESIA	370,892.03	3,978.00
GI SERVICES	47,073.00	969.00
EMERGENCY ROOM	2,112,847.98	1,883.00
RECOVERY ROOM	405,364.04	2,383.00
LABORATORY PATHOLOGIC	0.00	3,488.75
RADIOLOGY THERAPEUTIC	686,217.00	47,851.75
OCCUPATIONAL THERAPY	100,030.25	3,306.31
SPEECH PATHOLOGY	95,431.50	725.92
RENAL DIALYSIS	0.00	2,394.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,122.89	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	364,907.00	3,697.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,783.25	12,709.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	118,609.55	7,657.75
AUDIOLOGY	192.00	0.00
CARDIOLOGY	260,514.50	9,597.50
AMBULATORY SURGERY	107,555.75	20,842.50
OSTEOPATHIC SERVICES	0.00	0.00
E E G	29,501.74	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	456,952.28	12,850.75
OTHER LAB SERVICES	148,625.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	518.00	0.00
OTHER THERAPEUTIC SERVI	31.50	6,596.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,038,236.60	143,136.50
MRI SERVICES	516,137.25	10,444.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	6,415.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	349.83	15,241.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	395.77	6,920.50

TOTAL ANCILLARY	12,850,814.86	542,057.85
TOTAL ACCOMODATIONS	0.00	12,544.00
TOTAL CHARGES	12,850,814.86	554,601.85

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	25,276.20	ADJUSTMENTS	0.00
COVERED CHARGES	17,422.00	CONTRACTUAL ALLOW	12,340.02
NON-COVERED CHARGES	7,854.20	TOTAL MEDICAID LIAB	5,081.98
		LESS: COB	5,054.98
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	574.68-
		FEE SCHEDULE-LAB	574.68
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,421.02	0.00
MED/SURG SUPPLY	315.48	0.00
LABORATORY-GENERAL	0.00	281.75
RADIOLOGY-DIAGNOSTIC	342.25	0.00
CT SCAN	1,312.25	2,617.75
PHYSICAL THERAPY	1,905.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	3,621.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.75	100.25
ANESTHESIA	765.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,810.75	109.75
RECOVERY ROOM	629.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	234.25	0.00
OCCUPATIONAL THERAPY	721.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	423.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	70.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	958.75	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	4.50	75.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,521.25	977.45
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,422.00	7,854.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,422.00	7,854.20

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	443,113.28	ADJUSTMENTS	1,273.00
COVERED CHARGES	438,870.28	CONTRACTUAL ALLOW	352,670.28
NON-COVERED CHARGES	4,243.00	TOTAL MEDICAID LIAB	86,200.00
		LESS: COB	97.58
		LESS: COPAYMENT	1,722.00
		REIMBURSEMENT	84,380.42

TOTAL NUMBER OF CLAIMS 1,724

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,468.16	0.00
MED/SURG SUPPLY	934.49	0.00
LABORATORY-GENERAL	33,964.50	2,838.75
RADIOLOGY-DIAGNOSTIC	18,344.50	0.00
CT SCAN	22,832.50	1,213.00
PHYSICAL THERAPY	1,010.50	0.00
EKG/ECG	1,421.25	0.00
IV THERAPY	1,106.75	0.00
OPERATING ROOM	894.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,203.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	289,907.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	373.75	76.50
RADIOLOGY THERAPEUTIC	1,177.25	0.00
OCCUPATIONAL THERAPY	378.00	0.00
SPEECH PATHOLOGY	347.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	43.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,821.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	969.25	114.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	549.38	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,515.00	0.00
OTHER LAB SERVICES	1,395.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,212.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	438,870.28	4,243.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	438,870.28	4,243.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,215.25	ADJUSTMENTS	0.00
COVERED CHARGES	3,183.25	CONTRACTUAL ALLOW	2,574.31
NON-COVERED CHARGES	32.00	TOTAL MEDICAID LIAB	608.94
		LESS: COB	602.94
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	476.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	144.25	0.00
RADIOLOGY-DIAGNOSTIC	952.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	94.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.75	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,458.00	32.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,183.25	32.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,183.25	32.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE

BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,714,673.47	ADJUSTMENTS	20,087.54
COVERED CHARGES	1,652,317.34	CONTRACTUAL ALLOW	1,163,116.90
NON-COVERED CHARGES	62,356.13	TOTAL MEDICAID LIAB	489,200.44
		LESS: COB	4,054.77
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	484,887.67

TOTAL NUMBER OF CLAIMS 120

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	655,095.54	82.77
MED/SURG SUPPLY	173,689.27	0.00
LABORATORY-GENERAL	0.00	1,187.25
RADIOLOGY-DIAGNOSTIC	29,688.50	5,201.00
CT SCAN	40,336.00	639.00
PHYSICAL THERAPY	438.00	333.50
EKG/ECG	3,903.00	0.00
IV THERAPY	3,943.50	0.00
OPERATING ROOM	364,028.75	5,253.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,466.25	100.25
ANESTHESIA	64,566.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,870.50	0.00
RECOVERY ROOM	35,399.25	0.00
LABORATORY PATHOLOGIC	0.00	603.00
RADIOLOGY THERAPEUTIC	50,341.00	8,306.00
OCCUPATIONAL THERAPY	0.00	316.25
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	147.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	57,053.00	8,004.00
OTHER IMAGING SERVICES	2,504.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,229.25	7,365.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,603.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,923.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	33,400.00	75.75
OTHER LAB SERVICES	1,647.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	4,620.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	53,977.53	9,791.71
MRI SERVICES	11,067.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	5,776.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,652,317.34	57,656.13
TOTAL ACCOMODATIONS	0.00	4,700.00
TOTAL CHARGES	1,652,317.34	62,356.13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	32,639,832.59	ADJUSTMENTS	2,871,051.19
COVERED CHARGES	32,021,813.95	CONTRACTUAL ALLOW	19,209,991.24
NON-COVERED CHARGES	618,018.64	TOTAL MEDICAID LIAB	12,811,822.71
		LESS: COB	65,795.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,746,027.47

TOTAL NUMBER OF ADMISSIONS 2,951

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,167	0	4,333,344.00	520,553.00
NURSERY CARE CHARGES	2,251	0	1,508,692.00	6,054.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	18	0.00	0.00
TOTAL ROUTINE	8,418	18	5,842,036.00	526,607.00
SPECIAL CARE SERVICES				
C C U	661	0	977,981.00	0.00
I C U	1,961	0	2,409,892.00	0.00
N I C U	218	0	264,495.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,840	0	3,652,368.00	0.00
TOTAL ACCOMODATIONS	11,258	18	9,494,404.00	526,607.00

INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,794,080.43	0.00
MED/SURG SUPPLY	1,407,679.65	34,798.00
LABORATORY-GENERAL	2,977,167.67	947.16
RADIOLOGY-DIAGNOSTIC	466,504.10	0.00
CT SCAN	777,368.50	0.00
PHYSICAL THERAPY	82,999.04	0.00
EKG/ECG	75,528.89	0.00
IV THERAPY	300,321.78	0.00
OPERATING ROOM	2,545,738.31	0.00
LABOR/DELIVERY ROOM	1,149,128.92	0.00
RESPIRATORY SERVICES	1,320,328.07	0.00
ANESTHESIA	636,472.62	0.00
GI SERVICES	26,359.22	0.00
EMERGENCY ROOM	273,455.16	0.00
RECOVERY ROOM	326,265.62	0.00
LABORATORY PATHOLOGIC	72,786.12	0.00
RADIOLOGY THERAPEUTIC	64,928.55	0.00
OCCUPATIONAL THERAPY	40,076.71	0.00
SPEECH PATHOLOGY	8,262.88	0.00
RENAL DIALYSIS	12,349.30	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	99,859.11	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	567,093.79	37,417.81
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,604.95	0.00
AUDIOLOGY	64,002.90	0.00
CARDIOLOGY	489,525.53	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,121.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	475,096.42	0.00
OTHER LAB SERVICES	92,107.57	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,963.85
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	237,629.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	13,166.90	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,400.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16,284.82

TOTAL ANCILLARY	22,527,409.95	91,411.64
TOTAL ACCOMODATIONS	9,494,404.00	526,607.00
TOTAL CHARGES	32,021,813.95	618,018.64

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	729,897.38	ADJUSTMENTS	0.00
COVERED CHARGES	706,061.54	CONTRACTUAL ALLOW	163,803.41
NON-COVERED CHARGES	23,835.84	TOTAL MEDICAID LIAB	542,258.13
		LESS: COB	542,258.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 84

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	173	0	121,619.00	20,689.00
NURSERY CARE CHARGES	32	0	21,271.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	205	0	142,890.00	20,689.00
SPECIAL CARE SERVICES				
C C U	12	0	17,964.00	0.00
I C U	27	0	37,467.00	0.00
N I C U	6	0	7,074.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	45	0	62,505.00	0.00
TOTAL ACCOMODATIONS	250	0	205,395.00	20,689.00

ZERO PAID INPATIENT PAID CLAIMS

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,083.35	0.00
MED/SURG SUPPLY	25,203.26	3,146.84
LABORATORY-GENERAL	50,956.06	0.00
RADIOLOGY-DIAGNOSTIC	9,223.25	0.00
CT SCAN	13,462.50	0.00
PHYSICAL THERAPY	731.90	0.00
EKG/ECG	305.28	0.00
IV THERAPY	15,192.67	0.00
OPERATING ROOM	109,030.47	0.00
LABOR/DELIVERY ROOM	62,738.96	0.00
RESPIRATORY SERVICES	11,236.89	0.00
ANESTHESIA	28,389.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,723.55	0.00
RECOVERY ROOM	12,940.35	0.00
LABORATORY PATHOLOGIC	1,562.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	482.48	0.00
SPEECH PATHOLOGY	300.72	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	891.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	394.65	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	962.22	0.00
CARDIOLOGY	3,173.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,708.28	0.00
OTHER LAB SERVICES	931.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	500,666.54	3,146.84
TOTAL ACCOMODATIONS	205,395.00	20,689.00
TOTAL CHARGES	706,061.54	23,835.84

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,141,438.69	ADJUSTMENTS	118,529.23
COVERED CHARGES	12,378,855.03	CONTRACTUAL ALLOW	9,030,879.28
NON-COVERED CHARGES	762,583.66	TOTAL MEDICAID LIAB	3,347,975.75
		LESS: COB	2,234.18
		LESS: COPAYMENT	10,086.00
		REIMBURSEMENT	3,335,655.57
		ALL OTHER	3,092,077.01
		FEE SCHEDULE-LAB	243,578.56
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14,269

OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,916,423.92	11,905.07
MED/SURG SUPPLY	578,412.06	1,117.96
LABORATORY-GENERAL	0.00	19,229.60
RADIOLOGY-DIAGNOSTIC	603,281.19	39,754.00
CT SCAN	800,661.00	135,796.50
PHYSICAL THERAPY	235,438.90	3,299.01
EKG/ECG	59,742.25	0.00
IV THERAPY	89,680.33	5,971.79
OPERATING ROOM	1,664,009.82	116,387.94
LABOR/DELIVERY ROOM	6,055.04	0.00
RESPIRATORY SERVICES	171,793.97	0.00
ANESTHESIA	402,385.32	1,150.24
GI SERVICES	48,695.32	8,325.60
EMERGENCY ROOM	1,766,179.10	5,289.76
RECOVERY ROOM	410,151.18	0.00
LABORATORY PATHOLOGIC	0.00	78.00
RADIOLOGY THERAPEUTIC	781,372.05	58,036.47
OCCUPATIONAL THERAPY	101,605.53	326.22
SPEECH PATHOLOGY	72,911.15	751.80
RENAL DIALYSIS	0.00	896.24
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,853.24	147.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	45,733.60	0.00
OTHER IMAGING SERVICES	333,777.00	61,510.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,897.23	38,362.93
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	87,351.09	565.50
AUDIOLOGY	68.73	0.00
CARDIOLOGY	245,588.34	9,077.91
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,610.82	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	506,249.12	11,798.97
OTHER LAB SERVICES	142,759.89	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	14,463.36
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,020,239.34	147,544.61
MRI SERVICES	237,075.00	62,392.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	3,853.50	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	893.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	670.43

TOTAL ANCILLARY	12,378,855.03	755,743.66
TOTAL ACCOMODATIONS	0.00	6,840.00
TOTAL CHARGES	12,378,855.03	762,583.66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	56,508.31	ADJUSTMENTS	0.00
COVERED CHARGES	49,941.59	CONTRACTUAL ALLOW	39,930.14
NON-COVERED CHARGES	6,566.72	TOTAL MEDICAID LIAB	10,011.45
		LESS: COB	9,939.45
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	898.53-
		FEE SCHEDULE-LAB	898.53
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,437.96	0.00
MED/SURG SUPPLY	196.09	0.00
LABORATORY-GENERAL	0.00	118.98
RADIOLOGY-DIAGNOSTIC	1,866.75	0.00
CT SCAN	1,998.75	1,213.00
PHYSICAL THERAPY	4,837.14	0.00
EKG/ECG	305.28	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	157.31	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,347.33	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,217.40	0.00
OCCUPATIONAL THERAPY	668.01	0.00
SPEECH PATHOLOGY	2,062.08	343.68
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,092.00	208.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	365.16	591.49
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	590.03	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,672.98	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,225.32	1,129.82
MRI SERVICES	2,902.00	2,961.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	49,941.59	6,566.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,941.59	6,566.72

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE

BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	637,480.85	ADJUSTMENTS	2,090.00
COVERED CHARGES	615,547.29	CONTRACTUAL ALLOW	505,197.29
NON-COVERED CHARGES	21,933.56	TOTAL MEDICAID LIAB	110,350.00
		LESS: COB	362.97
		LESS: COPAYMENT	2,214.00
		REIMBURSEMENT	107,773.03

TOTAL NUMBER OF CLAIMS 2,207

OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,138.84	298.86
MED/SURG SUPPLY	1,471.30	0.00
LABORATORY-GENERAL	69,240.23	2,990.83
RADIOLOGY-DIAGNOSTIC	27,349.00	324.00
CT SCAN	33,547.00	10,082.00
PHYSICAL THERAPY	3,343.42	1,537.03
EKG/ECG	3,052.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,672.65	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	389,902.17	65.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,310.00	208.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,465.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,193.63	0.00
OTHER LAB SERVICES	1,861.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,414.96
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	2,902.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	110.13

TOTAL ANCILLARY	615,547.29	21,933.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	615,547.29	21,933.56

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,304.07	ADJUSTMENTS	0.00
COVERED CHARGES	2,671.61	CONTRACTUAL ALLOW	1,343.98
NON-COVERED CHARGES	3,632.46	TOTAL MEDICAID LIAB	1,327.63
		LESS: COB	1,321.63
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230.71	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	594.96	117.81
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	1,213.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	101.76	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	136.64	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,607.54	392.65
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	1,909.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,671.61	3,632.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,671.61	3,632.46

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE

BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	753,573.77	ADJUSTMENTS	6,471.54
COVERED CHARGES	736,675.80	CONTRACTUAL ALLOW	576,450.38
NON-COVERED CHARGES	16,897.97	TOTAL MEDICAID LIAB	160,225.42
		LESS: COB	0.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	160,084.42

TOTAL NUMBER OF CLAIMS 46

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP57

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317,147.12	32.00
MED/SURG SUPPLY	101,120.71	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,938.00	6,961.75
CT SCAN	2,659.00	0.00
PHYSICAL THERAPY	1,115.21	0.00
EKG/ECG	203.52	0.00
IV THERAPY	3,249.70	0.00
OPERATING ROOM	211,241.92	7,394.46
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	821.28	0.00
ANESTHESIA	31,385.12	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	11,939.57	0.00
LABORATORY PATHOLOGIC	0.00	141.07
RADIOLOGY THERAPEUTIC	11,153.15	402.75
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	94.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,756.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,586.55	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,626.00	162.70
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,637.95	996.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	806.64

TOTAL ANCILLARY	736,675.80	16,897.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	736,675.80	16,897.97

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN -BRUNSWICK MEMORIAL HOSP. AUT
2415 PARKWOOD DRIVE
BRUNSWICK GA 31520-4722

PROVIDER NUMBER 000000822A
NUMBER OF BEDS 337
TITLE XVIII NO: HOSP57

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	86,163,692.26	ADJUSTMENTS	4,166,682.32
COVERED CHARGES	79,224,254.37	CONTRACTUAL ALLOW	48,340,912.03
NON-COVERED CHARGES	6,939,437.89	TOTAL MEDICAID LIAB	30,883,342.34
		LESS: COB	127,059.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,756,282.57

TOTAL NUMBER OF ADMISSIONS 8,400

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,938	0	12,014,487.00	4,811,581.00
NURSERY CARE CHARGES	8,487	0	4,957,217.00	2,017,607.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	91	0.00	0.00
TOTAL ROUTINE	26,425	91	16,971,704.00	6,829,188.00
SPECIAL CARE SERVICES				
C C U	3,123	0	4,308,894.00	0.00
I C U	20	0	17,412.00	0.00
N I C U	1,380	0	2,450,282.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	11	0.00	12,100.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4,523	11	6,776,588.00	12,100.00
TOTAL ACCOMODATIONS	30,948	102	23,748,292.00	6,841,288.00

INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,958,537.15	0.00
MED/SURG SUPPLY	8,131,937.58	220.19
LABORATORY-GENERAL	9,448,955.83	0.00
RADIOLOGY-DIAGNOSTIC	688,263.45	0.00
CT SCAN	1,538,498.25	15,724.56
PHYSICAL THERAPY	241,406.24	0.00
EKG/ECG	190,082.01	0.00
IV THERAPY	1,117,266.95	0.00
OPERATING ROOM	3,151,849.95	0.00
LABOR/DELIVERY ROOM	5,899,326.00	0.00
RESPIRATORY SERVICES	3,192,856.81	0.00
ANESTHESIA	959,311.95	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	891,448.85	0.00
RECOVERY ROOM	649,259.21	0.00
LABORATORY PATHOLOGIC	282,937.66	0.00
RADIOLOGY THERAPEUTIC	44,634.36	0.00
OCCUPATIONAL THERAPY	83,457.07	0.00
SPEECH PATHOLOGY	347,969.25	0.00
RENAL DIALYSIS	107,336.12	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	30,876.52
PSYCHIATRIC SERVICES	27,966.46	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	836,704.16	0.00
BLOOD	5,185.52	0.00
BLOOD STORAGE & PRO.	622,436.92	1,176.88
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	304,508.29	0.00
AUDIOLOGY	1,079,763.79	0.00
CARDIOLOGY	1,194,830.13	0.00
AMBULATORY SURGERY	55,299.52	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	50,175.45	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	290,524.33	0.00
OTHER LAB SERVICES	192,046.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	75.04	0.00
OTHER THERAPEUTIC SERVI	0.00	38,528.71
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	516,849.27	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	5,990.54
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	374,262.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,632.49

TOTAL ANCILLARY	55,475,962.37	98,149.89
TOTAL ACCOMODATIONS	23,748,292.00	6,841,288.00
TOTAL CHARGES	79,224,254.37	6,939,437.89

ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	191,838.88	ADJUSTMENTS	0.00
COVERED CHARGES	185,787.88	CONTRACTUAL ALLOW	11,036.50
NON-COVERED CHARGES	6,051.00	TOTAL MEDICAID LIAB	174,751.38
		LESS: COB	174,751.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	46	0	30,866.00	2,931.00
NURSERY CARE CHARGES	23	0	12,799.00	3,120.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	69	0	43,665.00	6,051.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	69	0	43,665.00	6,051.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,367.67	0.00
MED/SURG SUPPLY	32,233.25	0.00
LABORATORY-GENERAL	17,191.20	0.00
RADIOLOGY-DIAGNOSTIC	187.07	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	285.20	0.00
IV THERAPY	750.75	0.00
OPERATING ROOM	7,259.86	0.00
LABOR/DELIVERY ROOM	42,846.13	0.00
RESPIRATORY SERVICES	841.62	0.00
ANESTHESIA	4,622.35	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,974.75	0.00
LABORATORY PATHOLOGIC	2,094.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,464.11	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	4,000.30	0.00
CARDIOLOGY	4,604.97	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	399.31	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	142,122.88	0.00
TOTAL ACCOMODATIONS	43,665.00	6,051.00
TOTAL CHARGES	185,787.88	6,051.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	39,793,217.08	ADJUSTMENTS	833,706.48
COVERED CHARGES	38,489,498.72	CONTRACTUAL ALLOW	25,009,264.72
NON-COVERED CHARGES	1,303,718.36	TOTAL MEDICAID LIAB	13,480,234.00
		LESS: COB	6,495.37
		LESS: COPAYMENT	16,119.00
		REIMBURSEMENT	13,457,619.63
		ALL OTHER	12,775,670.01
		FEE SCHEDULE-LAB	666,128.62
		INJECTABLE DRUGS	15,821.00

TOTAL NUMBER OF CLAIMS 33,450

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,655,245.51	71,332.70
MED/SURG SUPPLY	2,131,238.98	3,118.29
LABORATORY-GENERAL	15,952.08	161,350.16
RADIOLOGY-DIAGNOSTIC	1,350,564.99	135,372.30
CT SCAN	2,814,784.63	15,132.32
PHYSICAL THERAPY	294,246.00	173.00
EKG/ECG	189,058.91	0.00
IV THERAPY	242,877.65	5,986.68
OPERATING ROOM	806,578.68	25,556.33
LABOR/DELIVERY ROOM	765,080.89	3,294.88
RESPIRATORY SERVICES	195,964.89	448.98
ANESTHESIA	976,653.33	1,725.78
GI SERVICES	8,065.36	0.00
EMERGENCY ROOM	4,375,517.41	5,482.38
RECOVERY ROOM	812,792.66	1,994.31
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	194,985.36	587.00
OCCUPATIONAL THERAPY	94,813.00	0.00
SPEECH PATHOLOGY	38,018.00	169.00
RENAL DIALYSIS	0.00	1,298.54
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,009,131.42	1,674.99
PSYCHIATRIC SERVICES	181,839.12	4,663.76
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,193,832.54	67,173.18
BLOOD	559.87	0.00
BLOOD STORAGE & PRO.	79,054.79	8,028.89
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	393,976.34	25,986.31
AUDIOLOGY	0.00	0.00
CARDIOLOGY	264,545.83	10,191.80
AMBULATORY SURGERY	3,638,277.22	123,439.17
OSTEOPATHIC SERVICES	0.00	0.00
E E G	192,049.07	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,683,100.23	786.00
OTHER LAB SERVICES	135,820.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	470.74	179.96
OTHER THERAPEUTIC SERVI	0.00	4,531.31
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,044,320.98	584,126.17
MRI SERVICES	670,129.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	73.92
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	264.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	39,952.21	33,940.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	38,489,498.72	1,298,082.36
TOTAL ACCOMODATIONS	0.00	5,636.00
TOTAL CHARGES	38,489,498.72	1,303,718.36

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	80,412.86	ADJUSTMENTS	0.00
COVERED CHARGES	78,203.46	CONTRACTUAL ALLOW	30,506.18
NON-COVERED CHARGES	2,209.40	TOTAL MEDICAID LIAB	47,697.28
		LESS: COB	47,652.28
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,402.40-
		FEE SCHEDULE-LAB	1,402.40
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,785.60	0.00
MED/SURG SUPPLY	3,534.88	0.00
LABORATORY-GENERAL	0.00	468.58
RADIOLOGY-DIAGNOSTIC	1,819.01	754.14
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,483.70	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	3,728.83	0.00
RESPIRATORY SERVICES	175.35	0.00
ANESTHESIA	2,084.72	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,638.60	0.00
RECOVERY ROOM	1,296.44	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,001.22	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	245.58	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,490.81	197.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,317.02	0.00
AMBULATORY SURGERY	6,996.79	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,012.33	0.00
OTHER LAB SERVICES	1,829.18	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,738.42	98.03
MRI SERVICES	2,024.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	78,203.46	1,518.40
TOTAL ACCOMODATIONS	0.00	691.00
TOTAL CHARGES	78,203.46	2,209.40

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,460,464.96	ADJUSTMENTS	6,448.76
COVERED CHARGES	1,439,867.62	CONTRACTUAL ALLOW	1,271,891.27
NON-COVERED CHARGES	20,597.34	TOTAL MEDICAID LIAB	167,976.35
		LESS: COB	85.09
		LESS: COPAYMENT	2,001.00
		REIMBURSEMENT	165,890.26

TOTAL NUMBER OF CLAIMS 3,373

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,202.42	0.00
MED/SURG SUPPLY	45,708.54	0.00
LABORATORY-GENERAL	232,577.27	10,182.93
RADIOLOGY-DIAGNOSTIC	53,629.47	3,535.29
CT SCAN	51,782.56	2,494.83
PHYSICAL THERAPY	264.00	0.00
EKG/ECG	8,930.37	0.00
IV THERAPY	10,399.81	1,503.07
OPERATING ROOM	2,461.63	1,462.72
LABOR/DELIVERY ROOM	4,613.55	0.00
RESPIRATORY SERVICES	6,607.76	0.00
ANESTHESIA	2,984.28	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	748,839.84	255.08
RECOVERY ROOM	1,867.55	0.00
LABORATORY PATHOLOGIC	601.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	604.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	303.36	0.00
PSYCHIATRIC SERVICES	3,657.41	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	98,104.43	853.47
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	935.16	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,348.14	275.04
AUDIOLOGY	0.00	0.00
CARDIOLOGY	347.40	0.00
AMBULATORY SURGERY	15,446.41	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,147.43	0.00
OTHER LAB SERVICES	8,395.02	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	107.83	34.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,439,867.62	20,597.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,439,867.62	20,597.34

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,674.96	ADJUSTMENTS	0.00
COVERED CHARGES	3,477.51	CONTRACTUAL ALLOW	3,393.75
NON-COVERED CHARGES	197.45	TOTAL MEDICAID LIAB	83.76
		LESS: COB	83.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	425.43	0.00
MED/SURG SUPPLY	82.40	0.00
LABORATORY-GENERAL	371.56	0.00
RADIOLOGY-DIAGNOSTIC	192.68	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,643.57	197.45
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	761.87	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,477.51	197.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,477.51	197.45

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,052,993.63	ADJUSTMENTS	69,025.42
COVERED CHARGES	4,991,581.51	CONTRACTUAL ALLOW	3,765,587.99
NON-COVERED CHARGES	61,412.12	TOTAL MEDICAID LIAB	1,225,993.52
		LESS: COB	895.94
		LESS: COPAYMENT	660.00
		REIMBURSEMENT	1,224,437.58

TOTAL NUMBER OF CLAIMS 302

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,588,299.71	16,523.65
MED/SURG SUPPLY	1,280,522.15	0.00
LABORATORY-GENERAL	1,916.52	642.82
RADIOLOGY-DIAGNOSTIC	42,942.95	11,304.41
CT SCAN	48,953.17	0.00
PHYSICAL THERAPY	1,572.00	168.00
EKG/ECG	8,984.68	0.00
IV THERAPY	17,020.45	978.82
OPERATING ROOM	49,209.62	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,674.99	0.00
ANESTHESIA	246,427.17	2,481.36
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,357.32	0.00
RECOVERY ROOM	126,794.84	2,676.14
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	74,833.52	0.00
OCCUPATIONAL THERAPY	40,260.00	492.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	861.45
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,607.80	52.28
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	255,973.40	0.00
OTHER IMAGING SERVICES	13,718.23	1,916.85
BLOOD	1,611.19	0.00
BLOOD STORAGE & PRO.	8,879.08	1,321.10
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,370.37	1,966.53
AUDIOLOGY	0.00	0.00
CARDIOLOGY	93,960.39	0.00
AMBULATORY SURGERY	827,991.55	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	78,803.28	0.00
OTHER LAB SERVICES	2,325.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	820.59
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	112,736.92	18,926.41
MRI SERVICES	21,818.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.71	85.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	193.88

TOTAL ANCILLARY	4,991,581.51	61,412.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,991,581.51	61,412.12

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	16,533.73	ADJUSTMENTS	0.00
COVERED CHARGES	16,159.86	CONTRACTUAL ALLOW	11,159.86
NON-COVERED CHARGES	373.87	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	5,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,610.29	0.00
MED/SURG SUPPLY	2,284.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	695.75	119.47
CT SCAN	3,297.04	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	60.52	0.00
ANESTHESIA	1,219.74	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	536.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	2,846.84	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	913.18	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	695.75	254.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,159.86	373.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,159.86	373.87

INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	90,860,985.15	ADJUSTMENTS	5,399,940.78
COVERED CHARGES	84,810,663.23	CONTRACTUAL ALLOW	52,811,450.86
NON-COVERED CHARGES	6,050,321.92	TOTAL MEDICAID LIAB	31,999,212.37
		LESS: COB	160,876.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	31,838,336.37

TOTAL NUMBER OF ADMISSIONS 8,725

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18,472	1	14,230,973.00	4,166,130.55
NURSERY CARE CHARGES	8,601	0	5,568,591.00	1,733,067.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	84	0.00	0.00
TOTAL ROUTINE	27,073	85	19,799,564.00	5,899,197.55
SPECIAL CARE SERVICES				
C C U	2,831	0	4,084,184.00	0.00
I C U	12	0	8,888.00	0.00
N I C U	1,792	0	3,429,609.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4,635	0	7,522,681.00	0.00
TOTAL ACCOMODATIONS	31,708	85	27,322,245.00	5,899,197.55

INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,414,170.47	0.00
MED/SURG SUPPLY	8,937,751.41	606.52
LABORATORY-GENERAL	10,158,755.05	0.00
RADIOLOGY-DIAGNOSTIC	652,323.47	0.00
CT SCAN	1,617,082.17	0.00
PHYSICAL THERAPY	208,679.73	0.00
EKG/ECG	198,032.08	0.00
IV THERAPY	1,122,858.28	0.00
OPERATING ROOM	3,226,050.39	0.00
LABOR/DELIVERY ROOM	6,298,413.33	0.00
RESPIRATORY SERVICES	3,505,618.29	0.00
ANESTHESIA	1,038,711.26	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	938,196.17	0.00
RECOVERY ROOM	770,286.87	0.00
LABORATORY PATHOLOGIC	322,235.18	0.00
RADIOLOGY THERAPEUTIC	70,136.69	0.00
OCCUPATIONAL THERAPY	91,734.00	0.00
SPEECH PATHOLOGY	249,175.00	0.00
RENAL DIALYSIS	168,641.15	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	56,593.95
PSYCHIATRIC SERVICES	22,006.47	0.00
LITHOTRIPSY	45,633.17	0.00
OTHER IMAGING SERVICES	933,929.18	0.00
BLOOD	3,847.67	0.00
BLOOD STORAGE & PRO.	601,398.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	338,302.91	0.00
AUDIOLOGY	1,195,930.53	0.00
CARDIOLOGY	1,170,514.68	0.00
AMBULATORY SURGERY	31,157.96	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	77,034.61	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	237,251.47	0.00
OTHER LAB SERVICES	224,902.12	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	688.38	76,130.63
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	487,161.91	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	129,807.38	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	17,793.27

TOTAL ANCILLARY	57,488,418.23	151,124.37
TOTAL ACCOMODATIONS	27,322,245.00	5,899,197.55
TOTAL CHARGES	84,810,663.23	6,050,321.92

ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	307,996.27	ADJUSTMENTS	0.00
COVERED CHARGES	296,965.27	CONTRACTUAL ALLOW	134,615.14
NON-COVERED CHARGES	11,031.00	TOTAL MEDICAID LIAB	162,350.13
		LESS: COB	162,350.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	43	0	33,259.00	4,409.00
NURSERY CARE CHARGES	30	0	19,842.00	6,622.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	73	0	53,101.00	11,031.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	20	0	36,960.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	20	0	36,960.00	0.00
TOTAL ACCOMODATIONS	93	0	90,061.00	11,031.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,904.53	0.00
MED/SURG SUPPLY	29,534.42	0.00
LABORATORY-GENERAL	27,851.26	0.00
RADIOLOGY-DIAGNOSTIC	220.98	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,318.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	4,239.50	0.00
OPERATING ROOM	6,647.70	0.00
LABOR/DELIVERY ROOM	45,369.36	0.00
RESPIRATORY SERVICES	35,276.08	0.00
ANESTHESIA	2,829.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,914.02	0.00
LABORATORY PATHOLOGIC	758.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,165.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,010.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,013.75	0.00
ONCOLOGY	57.75	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,480.65	0.00
CARDIOLOGY	4,246.62	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	490.48	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	572.06	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,583.11	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,420.94	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	206,904.27	0.00
TOTAL ACCOMODATIONS	90,061.00	11,031.00
TOTAL CHARGES	296,965.27	11,031.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	40,831,235.84	ADJUSTMENTS	206,774.21
COVERED CHARGES	38,986,255.32	CONTRACTUAL ALLOW	27,865,177.49
NON-COVERED CHARGES	1,844,980.52	TOTAL MEDICAID LIAB	11,121,077.83
		LESS: COB	21,515.35
		LESS: COPAYMENT	16,629.00
		REIMBURSEMENT	11,082,933.48
		ALL OTHER	10,454,880.58
		FEE SCHEDULE-LAB	628,055.90
		INJECTABLE DRUGS	3.00-

TOTAL NUMBER OF CLAIMS 32,720

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,202,891.40	11,018.06
MED/SURG SUPPLY	2,087,516.15	25,598.49
LABORATORY-GENERAL	5,048.64	178,789.89
RADIOLOGY-DIAGNOSTIC	1,414,232.25	72,811.36
CT SCAN	2,533,764.02	343,474.26
PHYSICAL THERAPY	297,183.00	3,801.00
EKG/ECG	194,796.14	128.94
IV THERAPY	679,681.58	89,044.70
OPERATING ROOM	1,025,730.40	20,019.99
LABOR/DELIVERY ROOM	828,392.01	300.83
RESPIRATORY SERVICES	206,526.16	1,076.58
ANESTHESIA	896,049.69	6,544.22
GI SERVICES	5,259.64	0.00
EMERGENCY ROOM	4,740,072.43	8,953.10
RECOVERY ROOM	741,039.08	10,971.55
LABORATORY PATHOLOGIC	0.00	787.25
RADIOLOGY THERAPEUTIC	175,338.98	0.00
OCCUPATIONAL THERAPY	79,258.00	2,396.00
SPEECH PATHOLOGY	33,573.00	421.00
RENAL DIALYSIS	0.00	1,827.81
OUTPATIENT SERVICES	486.56	0.00
CLINIC SERVICES	1,409,921.61	9,860.07
PSYCHIATRIC SERVICES	173,814.89	317.79
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,108,814.87	196,225.83
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	66,934.41	5,017.32
ONCOLOGY	4,477.00	0.00
NUCLEAR MEDICINE	326,631.57	22,504.05
AUDIOLOGY	404.55	0.00
CARDIOLOGY	346,044.51	32,079.01
AMBULATORY SURGERY	3,242,350.02	80,270.99
OSTEOPATHIC SERVICES	0.00	0.00
E E G	426,128.77	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,771,805.17	11,636.26
OTHER LAB SERVICES	130,608.46	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	322.20	0.00
OTHER THERAPEUTIC SERVI	0.00	2,254.81
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,218,715.31	613,571.53
MRI SERVICES	610,505.64	69,349.10

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	16.47
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,937.21	922.83
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	16,478.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,677.04

TOTAL ANCILLARY	38,986,255.32	1,840,146.52
TOTAL ACCOMODATIONS	0.00	4,834.00
TOTAL CHARGES	38,986,255.32	1,844,980.52

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	73,881.69	ADJUSTMENTS	0.00
COVERED CHARGES	61,902.96	CONTRACTUAL ALLOW	30,774.63
NON-COVERED CHARGES	11,978.73	TOTAL MEDICAID LIAB	31,128.33
		LESS: COB	31,092.33
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	901.18-
		FEE SCHEDULE-LAB	901.18
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,232.77	0.00
MED/SURG SUPPLY	4,343.28	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	737.07	0.00
CT SCAN	0.00	3,599.71
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	155.69	0.00
IV THERAPY	1,240.74	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	8,685.88	0.00
RESPIRATORY SERVICES	276.13	0.00
ANESTHESIA	1,298.74	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,625.76	42.45
RECOVERY ROOM	1,420.83	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	81.08	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,172.34	544.03
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	509.36	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	2,864.31	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,036.73	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	79.73
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,810.45	3,797.37
MRI SERVICES	3,411.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	1,493.44
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	2,422.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	61,902.96	11,978.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	61,902.96	11,978.73

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,875,547.44	ADJUSTMENTS	2,082.00
COVERED CHARGES	1,820,792.90	CONTRACTUAL ALLOW	1,626,989.51
NON-COVERED CHARGES	54,754.54	TOTAL MEDICAID LIAB	193,803.39
		LESS: COB	58.03
		LESS: COPAYMENT	4,173.00
		REIMBURSEMENT	189,572.36

TOTAL NUMBER OF CLAIMS 3,877

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,308.56	0.00
MED/SURG SUPPLY	49,640.64	291.48
LABORATORY-GENERAL	304,307.39	10,795.45
RADIOLOGY-DIAGNOSTIC	69,987.99	1,353.34
CT SCAN	46,004.30	17,555.05
PHYSICAL THERAPY	1,064.00	0.00
EKG/ECG	9,888.25	0.00
IV THERAPY	29,032.86	7,333.42
OPERATING ROOM	186.36	0.00
LABOR/DELIVERY ROOM	1,804.98	0.00
RESPIRATORY SERVICES	7,189.75	0.00
ANESTHESIA	2,695.81	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,074,227.04	0.00
RECOVERY ROOM	1,137.28	0.00
LABORATORY PATHOLOGIC	1,795.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,193.27	0.00
PSYCHIATRIC SERVICES	6,200.03	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	88,748.51	17,008.34
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	12,262.19	401.75
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,798.30	0.00
OTHER LAB SERVICES	7,283.72	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.05	15.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,820,792.90	54,754.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,820,792.90	54,754.54

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	18,112.70	ADJUSTMENTS	0.00
COVERED CHARGES	15,636.42	CONTRACTUAL ALLOW	13,971.26
NON-COVERED CHARGES	2,476.28	TOTAL MEDICAID LIAB	1,665.16
		LESS: COB	1,656.16
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,784.39	102.23
MED/SURG SUPPLY	336.71	9.93
LABORATORY-GENERAL	2,953.77	887.42
RADIOLOGY-DIAGNOSTIC	198.46	0.00
CT SCAN	1,376.03	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	146.88	0.00
IV THERAPY	87.69	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	159.71	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,239.00	1,205.21
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	158.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	336.86	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,858.25	271.49
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	15,636.42	2,476.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,636.42	2,476.28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,233,199.81	ADJUSTMENTS	28,342.61
COVERED CHARGES	5,130,578.45	CONTRACTUAL ALLOW	4,066,974.59
NON-COVERED CHARGES	102,621.36	TOTAL MEDICAID LIAB	1,063,603.86
		LESS: COB	8,388.80
		LESS: COPAYMENT	957.00
		REIMBURSEMENT	1,054,258.06

TOTAL NUMBER OF CLAIMS 302

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0025GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,008,661.69	0.00
MED/SURG SUPPLY	1,056,969.55	23,279.61
LABORATORY-GENERAL	0.00	262.39
RADIOLOGY-DIAGNOSTIC	27,290.45	11,892.50
CT SCAN	17,364.49	7,199.42
PHYSICAL THERAPY	15,868.00	0.00
EKG/ECG	5,276.07	0.00
IV THERAPY	76,378.02	9,735.85
OPERATING ROOM	84,309.40	0.00
LABOR/DELIVERY ROOM	3,597.35	0.00
RESPIRATORY SERVICES	4,225.24	0.00
ANESTHESIA	256,529.17	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,581.63	0.00
RECOVERY ROOM	139,180.41	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	78,498.95	0.00
OCCUPATIONAL THERAPY	12,896.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,930.19	468.31
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	354,626.41	0.00
OTHER IMAGING SERVICES	8,762.40	2,023.15
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,512.15	0.00
ONCOLOGY	407.00	0.00
NUCLEAR MEDICINE	18,401.15	2,713.77
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,885.79	5,588.54
AMBULATORY SURGERY	734,272.55	26,631.50
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	44,566.31	0.00
OTHER LAB SERVICES	1,969.34	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,368.97
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	98,829.88	11,457.35
MRI SERVICES	15,788.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,130,578.45	102,621.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,130,578.45	102,621.36

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL HOSP
11 UPPER RIVERDALE ROAD SW
RIVERDALE GA 30274-2615

PROVIDER NUMBER 000000404A
NUMBER OF BEDS 331
TITLE XVIII NO: HPH0025GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	206,698.30	ADJUSTMENTS	2,475.30
COVERED CHARGES	205,393.75	CONTRACTUAL ALLOW	114,107.17
NON-COVERED CHARGES	1,304.55	TOTAL MEDICAID LIAB	91,286.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	91,286.58

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	57	0	19,665.00	180.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	57	0	19,665.00	180.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	57	0	19,665.00	180.00

INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,348.50	0.00
MED/SURG SUPPLY	22,378.80	0.00
LABORATORY-GENERAL	17,277.15	0.00
RADIOLOGY-DIAGNOSTIC	2,269.60	0.00
CT SCAN	3,063.20	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,020.05	0.00
IV THERAPY	1,845.00	0.00
OPERATING ROOM	19,433.70	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,691.85	0.00
ANESTHESIA	6,248.85	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,054.00	0.00
RECOVERY ROOM	333.15	0.00
LABORATORY PATHOLOGIC	21.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,109.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,442.05	416.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,304.35	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,944.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,943.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	708.05
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	185,728.75	1,124.55
TOTAL ACCOMODATIONS	19,665.00	180.00
TOTAL CHARGES	205,393.75	1,304.55

ZERO PAID INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,685,991.13	ADJUSTMENTS	76,502.90
COVERED CHARGES	1,585,063.75	CONTRACTUAL ALLOW	686,250.57
NON-COVERED CHARGES	100,927.38	TOTAL MEDICAID LIAB	898,813.18
		LESS: COB	1,000.00
		LESS: COPAYMENT	2,793.00
		REIMBURSEMENT	895,020.18
		ALL OTHER	850,341.02
		FEE SCHEDULE-LAB	44,679.16
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,953

OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,687.73	5,831.85
MED/SURG SUPPLY	52,606.77	3,393.40
LABORATORY-GENERAL	0.00	14,519.70
RADIOLOGY-DIAGNOSTIC	86,065.35	137.35
CT SCAN	120,868.45	1,969.45
PHYSICAL THERAPY	24,829.10	0.00
EKG/ECG	10,626.00	0.00
IV THERAPY	19,270.00	205.00
OPERATING ROOM	41,598.50	3,912.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,395.20	137.45
ANESTHESIA	18,520.45	4,524.20
GI SERVICES	0.00	0.00
EMERGENCY ROOM	465,387.75	541.00
RECOVERY ROOM	829.70	327.75
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	25,577.70	414.15
SPEECH PATHOLOGY	83,878.80	878.20
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	99,831.42	971.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	576.75	8,334.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,468.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,481.90	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	62,341.40	1,352.70
OTHER LAB SERVICES	12,375.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	254,144.68	50,607.63
MRI SERVICES	19,812.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,869.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	890.75	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,585,063.75	100,927.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,585,063.75	100,927.38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	843.65	ADJUSTMENTS	0.00
COVERED CHARGES	843.65	CONTRACTUAL ALLOW	178.82
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	664.83
		LESS: COB	655.83
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	8.49-
		FEE SCHEDULE-LAB	8.49
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	20.65	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	433.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	64.95	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	205.25	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	843.65	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	843.65	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	269,745.09	ADJUSTMENTS	2,978.00
COVERED CHARGES	267,564.84	CONTRACTUAL ALLOW	238,564.84
NON-COVERED CHARGES	2,180.25	TOTAL MEDICAID LIAB	29,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	28,607.00

TOTAL NUMBER OF CLAIMS 580

OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,126.44	0.00
MED/SURG SUPPLY	4,760.45	0.00
LABORATORY-GENERAL	14,201.60	1,506.30
RADIOLOGY-DIAGNOSTIC	8,560.50	0.00
CT SCAN	2,869.90	0.00
PHYSICAL THERAPY	715.75	0.00
EKG/ECG	2,028.60	0.00
IV THERAPY	3,280.00	0.00
OPERATING ROOM	1,623.10	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,763.50	0.00
ANESTHESIA	1,067.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	189,045.00	0.00
RECOVERY ROOM	109.25	0.00
LABORATORY PATHOLOGIC	21.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	283.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	571.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	308.95
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,420.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,973.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	326.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	39.00
AMBULANCE	0.00	0.00
CAST ROOM	143.10	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	267,564.84	2,180.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	267,564.84	2,180.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	95,761.27	ADJUSTMENTS	7,679.13
COVERED CHARGES	94,102.12	CONTRACTUAL ALLOW	55,640.39
NON-COVERED CHARGES	1,659.15	TOTAL MEDICAID LIAB	38,461.73
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	38,446.73

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,194.52	0.00
MED/SURG SUPPLY	7,393.35	861.60
LABORATORY-GENERAL	0.00	14.40
RADIOLOGY-DIAGNOSTIC	1,000.50	97.65
CT SCAN	949.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	289.80	0.00
IV THERAPY	615.00	0.00
OPERATING ROOM	21,979.05	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,267.05	0.00
ANESTHESIA	8,262.45	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	650.00	0.00
RECOVERY ROOM	573.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,098.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,346.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,483.30	685.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	94,102.12	1,659.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,102.12	1,659.15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
109 RANDOLPH STREET	000001427A	40	SERVICE DATES 07/01/2004 THROUGH 06/30/2005
	TITLE XVIII NO: HOSP3		
CUTHBERT GA 39840-6200			

****** NO DATA ******

INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	540,665.02	ADJUSTMENTS	7,118.36
COVERED CHARGES	535,940.42	CONTRACTUAL ALLOW	339,819.98
NON-COVERED CHARGES	4,724.60	TOTAL MEDICAID LIAB	196,120.44
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	196,120.44

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	133	0	45,885.00	1,520.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	133	0	45,885.00	1,520.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	133	0	45,885.00	1,520.00

INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,417.77	0.00
MED/SURG SUPPLY	44,904.47	0.00
LABORATORY-GENERAL	42,556.78	0.00
RADIOLOGY-DIAGNOSTIC	7,365.90	0.00
CT SCAN	37,429.65	0.00
PHYSICAL THERAPY	350.00	0.00
EKG/ECG	3,418.50	0.00
IV THERAPY	45,420.20	0.00
OPERATING ROOM	34,934.45	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,126.05	0.00
ANESTHESIA	8,404.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,302.00	0.00
RECOVERY ROOM	634.85	0.00
LABORATORY PATHOLOGIC	64.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	267.40	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,474.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,047.70	1,501.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	32,161.60	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,774.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,703.10
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	490,055.42	3,204.60
TOTAL ACCOMODATIONS	45,885.00	1,520.00
TOTAL CHARGES	535,940.42	4,724.60

ZERO PAID INPATIENT PAID CLAIMS

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,893,293.37	ADJUSTMENTS	12,880.99
COVERED CHARGES	1,750,377.36	CONTRACTUAL ALLOW	743,414.10
NON-COVERED CHARGES	142,916.01	TOTAL MEDICAID LIAB	1,006,963.26
		LESS: COB	0.00
		LESS: COPAYMENT	2,754.00
		REIMBURSEMENT	1,004,209.26
		ALL OTHER	959,251.87
		FEE SCHEDULE-LAB	44,957.39
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,088

OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157,127.36	4,163.95
MED/SURG SUPPLY	51,531.80	1,986.40
LABORATORY-GENERAL	0.00	10,790.15
RADIOLOGY-DIAGNOSTIC	104,331.75	1,573.45
CT SCAN	120,779.10	18,841.35
PHYSICAL THERAPY	33,505.95	4,341.40
EKG/ECG	13,930.30	199.00
IV THERAPY	38,846.10	4,415.70
OPERATING ROOM	36,345.65	2,581.20
LABOR/DELIVERY ROOM	4,389.50	0.00
RESPIRATORY SERVICES	23,916.00	0.00
ANESTHESIA	21,734.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	504,849.50	1,745.00
RECOVERY ROOM	1,992.20	0.00
LABORATORY PATHOLOGIC	0.00	151.55
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,435.15	0.00
SPEECH PATHOLOGY	127,512.90	3,864.70
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	288.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	112,099.75	2,355.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	578.05	3,060.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,632.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,556.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55,114.55	10,804.10
OTHER LAB SERVICES	20,635.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	279,919.65	70,293.51
MRI SERVICES	22,754.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	589.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	860.40	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	151.20

TOTAL ANCILLARY	1,750,377.36	142,196.01
TOTAL ACCOMODATIONS	0.00	720.00
TOTAL CHARGES	1,750,377.36	142,916.01

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	22.30	ADJUSTMENTS	0.00
COVERED CHARGES	22.30	CONTRACTUAL ALLOW	19.30
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.17
		FEE SCHEDULE-LAB	0.17-
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22.30	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22.30	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22.30	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	267,432.69	ADJUSTMENTS	50.00
COVERED CHARGES	263,878.79	CONTRACTUAL ALLOW	235,528.79
NON-COVERED CHARGES	3,553.90	TOTAL MEDICAID LIAB	28,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	522.00
		REIMBURSEMENT	27,828.00

TOTAL NUMBER OF CLAIMS 567

OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,080.89	0.00
MED/SURG SUPPLY	2,667.45	0.00
LABORATORY-GENERAL	10,723.90	816.70
RADIOLOGY-DIAGNOSTIC	9,147.25	133.70
CT SCAN	2,035.85	0.00
PHYSICAL THERAPY	1,921.15	0.00
EKG/ECG	398.00	0.00
IV THERAPY	2,242.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,879.50	0.00
RESPIRATORY SERVICES	742.10	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	205,174.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,032.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	19.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	647.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,016.25	2,584.50
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	169.55	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	263,878.79	3,553.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	263,878.79	3,553.90

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP3

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	261,702.41	ADJUSTMENTS	0.00
COVERED CHARGES	248,577.66	CONTRACTUAL ALLOW	159,655.32
NON-COVERED CHARGES	13,124.75	TOTAL MEDICAID LIAB	88,922.34
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	88,766.34

TOTAL NUMBER OF CLAIMS 27

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP
109 RANDOLPH STREET
CUTHBERT GA 39840-6200

PROVIDER NUMBER 000001427A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP3

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,522.05	244.60
MED/SURG SUPPLY	19,557.26	2,287.85
LABORATORY-GENERAL	0.00	414.65
RADIOLOGY-DIAGNOSTIC	1,686.90	141.50
CT SCAN	3,401.00	1,972.30
PHYSICAL THERAPY	823.35	0.00
EKG/ECG	1,194.00	0.00
IV THERAPY	30,927.20	0.00
OPERATING ROOM	77,177.25	5,388.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,394.85	0.00
ANESTHESIA	18,623.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,900.00	0.00
RECOVERY ROOM	2,315.70	0.00
LABORATORY PATHOLOGIC	0.00	108.25
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,056.60	0.00
SPEECH PATHOLOGY	4,191.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	471.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,241.70	244.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,094.00	2,323.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	248,577.66	13,124.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	248,577.66	13,124.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PATTERSON HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
109 RANDOLPH STREET	000001427A	40	SERVICE DATES 07/01/2005 THROUGH 06/30/2006
	TITLE XVIII NO: HOSP3		
CUTHBERT GA 39840-6200			

****** NO DATA ******

INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,849,907.68	ADJUSTMENTS	612,158.06
COVERED CHARGES	9,755,632.68	CONTRACTUAL ALLOW	6,147,746.45
NON-COVERED CHARGES	94,275.00	TOTAL MEDICAID LIAB	3,607,886.23
		LESS: COB	7,062.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,600,823.41

TOTAL NUMBER OF ADMISSIONS 673

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,953	77	875,770.00	48,245.00
NURSERY CARE CHARGES	416	0	187,555.00	4,970.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,369	77	1,063,325.00	53,215.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	587	0	666,245.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	587	0	666,245.00	0.00
TOTAL ACCOMODATIONS	2,956	77	1,729,570.00	53,215.00

INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,277,931.88	0.00
MED/SURG SUPPLY	1,660,543.14	80.00
LABORATORY-GENERAL	740,097.89	6,416.00
RADIOLOGY-DIAGNOSTIC	197,785.00	0.00
CT SCAN	212,602.00	0.00
PHYSICAL THERAPY	17,788.03	0.00
EKG/ECG	191,672.35	0.00
IV THERAPY	285,506.39	2,396.00
OPERATING ROOM	61,705.00	0.00
LABOR/DELIVERY ROOM	655,167.00	0.00
RESPIRATORY SERVICES	1,202,980.00	0.00
ANESTHESIA	26,152.00	0.00
GI SERVICES	14,860.00	0.00
EMERGENCY ROOM	159,165.00	0.00
RECOVERY ROOM	28,584.00	0.00
LABORATORY PATHOLOGIC	9,933.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	110.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	4,032.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,743.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	44,101.00	0.00
BLOOD	49,900.00	0.00
BLOOD STORAGE & PRO.	66,326.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,888.00	0.00
AUDIOLOGY	8,682.00	0.00
CARDIOLOGY	60.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,546.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,879.00	25,268.00
OTHER LAB SERVICES	34,126.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,616.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,456.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,900.00	47.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	78.00

TOTAL ANCILLARY	8,026,062.68	41,060.00
TOTAL ACCOMODATIONS	1,729,570.00	53,215.00
TOTAL CHARGES	9,755,632.68	94,275.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,912.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,831.00	CONTRACTUAL ALLOW	4,950.94
NON-COVERED CHARGES	81.00	TOTAL MEDICAID LIAB	2,880.06
		LESS: COB	2,880.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	850.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	850.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	850.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	207.00	0.00
MED/SURG SUPPLY	622.00	0.00
LABORATORY-GENERAL	232.00	53.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	80.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	5,750.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	90.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	28.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,981.00	81.00
TOTAL ACCOMODATIONS	850.00	0.00
TOTAL CHARGES	7,831.00	81.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,137,132.32	ADJUSTMENTS	26,694.55
COVERED CHARGES	6,429,908.30	CONTRACTUAL ALLOW	3,508,206.60
NON-COVERED CHARGES	707,224.02	TOTAL MEDICAID LIAB	2,921,701.70
		LESS: COB	643.80
		LESS: COPAYMENT	10,737.00
		REIMBURSEMENT	2,910,320.90
		ALL OTHER	2,817,662.04
		FEE SCHEDULE-LAB	92,500.33
		INJECTABLE DRUGS	158.53

TOTAL NUMBER OF CLAIMS 10,744

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	368,184.14	20,463.69
MED/SURG SUPPLY	740,212.37	44,844.00
LABORATORY-GENERAL	0.00	63,022.00
RADIOLOGY-DIAGNOSTIC	435,263.00	28,544.00
CT SCAN	299,252.00	38,422.00
PHYSICAL THERAPY	120,774.00	18,722.00
EKG/ECG	80,640.00	7,990.00
IV THERAPY	63,038.00	5,052.00
OPERATING ROOM	107,170.00	28,519.00
LABOR/DELIVERY ROOM	64,386.00	208.00
RESPIRATORY SERVICES	90,445.01	14,080.00
ANESTHESIA	34,290.00	2,462.00
GI SERVICES	53,394.00	13,736.50
EMERGENCY ROOM	1,851,143.00	18,784.00
RECOVERY ROOM	58,894.00	3,726.00
LABORATORY PATHOLOGIC	0.00	46.00
RADIOLOGY THERAPEUTIC	0.00	407.00
OCCUPATIONAL THERAPY	12,525.00	2,946.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	512,893.00	3,889.00
PSYCHIATRIC SERVICES	388,209.00	158,174.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	220,965.00	20,730.00
BLOOD	0.00	500.00
BLOOD STORAGE & PRO.	4,559.00	7,644.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,656.00	812.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,265.00	199.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	137,052.00	10,248.00
OTHER LAB SERVICES	76,560.00	1,770.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,293.00	1,788.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	676,423.78	187,438.83
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,392.00	298.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	281.00

TOTAL ANCILLARY	6,429,908.30	705,746.02
TOTAL ACCOMODATIONS	0.00	1,478.00
TOTAL CHARGES	6,429,908.30	707,224.02

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,689.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,262.00	CONTRACTUAL ALLOW	79.50
NON-COVERED CHARGES	427.00	TOTAL MEDICAID LIAB	1,182.50
		LESS: COB	1,179.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.00	0.00
MED/SURG SUPPLY	10.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	241.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,007.00	316.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	111.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,262.00	427.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,262.00	427.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	559,264.97	ADJUSTMENTS	294.00
COVERED CHARGES	544,086.97	CONTRACTUAL ALLOW	489,489.97
NON-COVERED CHARGES	15,178.00	TOTAL MEDICAID LIAB	54,597.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,173.00
		REIMBURSEMENT	53,424.00

TOTAL NUMBER OF CLAIMS 1,092

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,488.97	29.00
MED/SURG SUPPLY	14,894.00	38.00
LABORATORY-GENERAL	34,676.00	9,609.00
RADIOLOGY-DIAGNOSTIC	21,227.00	1,511.00
CT SCAN	7,379.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,241.00	0.00
IV THERAPY	2,269.00	40.00
OPERATING ROOM	0.00	930.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	232.00	615.00
ANESTHESIA	249.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	419,829.00	1,819.00
RECOVERY ROOM	727.00	0.00
LABORATORY PATHOLOGIC	63.00	63.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	375.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,167.00	407.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	90.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,820.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	676.00	0.00
OTHER LAB SERVICES	1,770.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4.00	27.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	544,086.97	15,178.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	544,086.97	15,178.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,975.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,175.00	CONTRACTUAL ALLOW	5,042.00
NON-COVERED CHARGES	7,800.00	TOTAL MEDICAID LIAB	133.00
		LESS: COB	130.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413.00	143.00
MED/SURG SUPPLY	237.00	130.00
LABORATORY-GENERAL	1,764.00	253.00
RADIOLOGY-DIAGNOSTIC	1,573.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	232.00	0.00
IV THERAPY	0.00	40.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	441.00	7,144.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	125.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	390.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	90.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,175.00	7,800.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,175.00	7,800.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	255,880.98	ADJUSTMENTS	0.00
COVERED CHARGES	240,308.98	CONTRACTUAL ALLOW	146,192.32
NON-COVERED CHARGES	15,572.00	TOTAL MEDICAID LIAB	94,116.66
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	94,068.66

TOTAL NUMBER OF CLAIMS 22

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,445.48	0.00
MED/SURG SUPPLY	75,191.50	0.00
LABORATORY-GENERAL	0.00	1,132.00
RADIOLOGY-DIAGNOSTIC	1,142.00	546.00
CT SCAN	2,454.00	0.00
PHYSICAL THERAPY	499.00	0.00
EKG/ECG	348.00	0.00
IV THERAPY	2,899.00	0.00
OPERATING ROOM	12,673.00	1,170.00
LABOR/DELIVERY ROOM	540.00	0.00
RESPIRATORY SERVICES	736.00	123.00
ANESTHESIA	4,763.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	970.00	0.00
RECOVERY ROOM	6,295.00	0.00
LABORATORY PATHOLOGIC	0.00	199.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	104,629.00	11,520.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,220.00	182.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	444.00	270.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,634.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	149.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,426.00	281.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	240,308.98	15,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	240,308.98	15,572.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,536,791.35	ADJUSTMENTS	22,784.04
COVERED CHARGES	1,530,131.35	CONTRACTUAL ALLOW	935,208.78
NON-COVERED CHARGES	6,660.00	TOTAL MEDICAID LIAB	594,922.57
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	594,922.57

TOTAL NUMBER OF ADMISSIONS 137

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	375	0	167,835.00	1,460.00
NURSERY CARE CHARGES	50	0	22,505.00	70.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	425	0	190,340.00	1,530.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	59	0	66,965.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	59	0	66,965.00	0.00
TOTAL ACCOMODATIONS	484	0	257,305.00	1,530.00

INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	271,179.57	0.00
MED/SURG SUPPLY	253,704.00	0.00
LABORATORY-GENERAL	151,314.78	848.00
RADIOLOGY-DIAGNOSTIC	25,647.00	0.00
CT SCAN	46,260.00	0.00
PHYSICAL THERAPY	2,605.00	0.00
EKG/ECG	48,614.00	0.00
IV THERAPY	58,247.00	0.00
OPERATING ROOM	14,011.00	0.00
LABOR/DELIVERY ROOM	162,789.00	0.00
RESPIRATORY SERVICES	127,177.00	0.00
ANESTHESIA	4,475.00	0.00
GI SERVICES	1,436.00	0.00
EMERGENCY ROOM	38,097.00	0.00
RECOVERY ROOM	6,234.00	0.00
LABORATORY PATHOLOGIC	1,015.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	4,032.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	250.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,232.00	0.00
BLOOD	8,265.00	0.00
BLOOD STORAGE & PRO.	10,006.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,502.00	0.00
AUDIOLOGY	2,628.00	0.00
CARDIOLOGY	15.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,361.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,480.00	0.00
OTHER LAB SERVICES	10,620.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	202.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,710.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,272,826.35	5,130.00
TOTAL ACCOMODATIONS	257,305.00	1,530.00
TOTAL CHARGES	1,530,131.35	6,660.00

ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,452,728.81	ADJUSTMENTS	4,112.43
COVERED CHARGES	1,408,812.69	CONTRACTUAL ALLOW	760,339.97
NON-COVERED CHARGES	43,916.12	TOTAL MEDICAID LIAB	648,472.72
		LESS: COB	0.00
		LESS: COPAYMENT	1,086.00
		REIMBURSEMENT	647,386.72
		ALL OTHER	630,008.43
		FEE SCHEDULE-LAB	17,378.29
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,305

OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,044.69	2,229.12
MED/SURG SUPPLY	112,432.00	1,867.00
LABORATORY-GENERAL	0.00	10,325.00
RADIOLOGY-DIAGNOSTIC	95,394.00	2,067.00
CT SCAN	94,575.00	2,736.00
PHYSICAL THERAPY	45,213.00	538.00
EKG/ECG	17,337.00	0.00
IV THERAPY	10,433.00	0.00
OPERATING ROOM	17,250.00	196.00
LABOR/DELIVERY ROOM	32,515.00	0.00
RESPIRATORY SERVICES	23,190.00	1,722.00
ANESTHESIA	4,693.00	0.00
GI SERVICES	11,017.00	0.00
EMERGENCY ROOM	436,678.00	0.00
RECOVERY ROOM	8,816.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	107,178.00	500.00
PSYCHIATRIC SERVICES	117,129.00	3,521.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	38,793.00	294.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	90.00	1,197.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,068.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,610.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,207.00	0.00
OTHER LAB SERVICES	4,195.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	138,955.00	16,305.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	108.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	76.00

TOTAL ANCILLARY	1,408,812.69	43,681.12
TOTAL ACCOMODATIONS	0.00	235.00
TOTAL CHARGES	1,408,812.69	43,916.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	27.00	ADJUSTMENTS	0.00
COVERED CHARGES	0.00	CONTRACTUAL ALLOW	0.00
NON-COVERED CHARGES	27.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	27.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	0.00	27.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	0.00	27.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	124,676.88	ADJUSTMENTS	50.00
COVERED CHARGES	123,089.58	CONTRACTUAL ALLOW	109,489.58
NON-COVERED CHARGES	1,587.30	TOTAL MEDICAID LIAB	13,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	13,426.00

TOTAL NUMBER OF CLAIMS 272

OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005
TITLE XVIII NO: HPH0060GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,553.88	0.00
MED/SURG SUPPLY	1,988.00	0.00
LABORATORY-GENERAL	8,355.70	1,587.30
RADIOLOGY-DIAGNOSTIC	3,600.00	0.00
CT SCAN	912.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	232.00	0.00
IV THERAPY	482.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	102,502.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	464.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	123,089.58	1,587.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,089.58	1,587.30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	65,097.00	ADJUSTMENTS	0.00
COVERED CHARGES	65,068.00	CONTRACTUAL ALLOW	39,399.82
NON-COVERED CHARGES	29.00	TOTAL MEDICAID LIAB	25,668.18
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	25,650.18

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,312.00	29.00
MED/SURG SUPPLY	8,238.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	747.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	285.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	200.00	0.00
OPERATING ROOM	2,113.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	414.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	51,575.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	184.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	65,068.00	29.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,068.00	29.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST HOSP AND MEDICAL CTR
501 FAIRBURN RD SW
ATLANTA GA 30331-2012

PROVIDER NUMBER 000001746A
NUMBER OF BEDS 115
TITLE XVIII NO: HPH0060GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 01/14/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,917,437.17	ADJUSTMENTS	111,046.25
COVERED CHARGES	5,802,764.63	CONTRACTUAL ALLOW	2,886,243.80
NON-COVERED CHARGES	114,672.54	TOTAL MEDICAID LIAB	2,916,520.83
		LESS: COB	23,973.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,892,547.43

TOTAL NUMBER OF ADMISSIONS 1,074

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,787	0	619,500.00	96,345.00
NURSERY CARE CHARGES	784	0	235,210.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,571	0	854,710.00	96,345.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	169	1	169,310.00	590.00
N I C U	0	0	0.00	0.00
PED I C U	4	0	1,770.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	173	1	171,080.00	590.00
TOTAL ACCOMODATIONS	2,744	1	1,025,790.00	96,935.00

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	881,073.57	0.00
MED/SURG SUPPLY	1,298,364.71	0.00
LABORATORY-GENERAL	521,480.77	0.00
RADIOLOGY-DIAGNOSTIC	92,212.82	0.00
CT SCAN	91,485.75	0.00
PHYSICAL THERAPY	21,566.75	0.00
EKG/ECG	12,688.50	0.00
IV THERAPY	90,740.00	0.00
OPERATING ROOM	189,535.50	0.00
LABOR/DELIVERY ROOM	625,167.72	0.00
RESPIRATORY SERVICES	364,618.00	0.00
ANESTHESIA	58,669.00	0.00
GI SERVICES	1,209.00	0.00
EMERGENCY ROOM	60,703.25	0.00
RECOVERY ROOM	94,731.75	0.00
LABORATORY PATHOLOGIC	30,091.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,042.75	0.00
SPEECH PATHOLOGY	1,631.50	0.00
RENAL DIALYSIS	8,280.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	26,426.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	11,732.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,158.25	0.00
AUDIOLOGY	15,738.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	393.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	253,720.54	4,576.75
OTHER LAB SERVICES	14,818.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,426.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	33.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	42.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,352.00

TOTAL ANCILLARY	4,776,974.63	17,737.54
TOTAL ACCOMODATIONS	1,025,790.00	96,935.00
TOTAL CHARGES	5,802,764.63	114,672.54

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	429,320.03	ADJUSTMENTS	0.00
COVERED CHARGES	419,070.53	CONTRACTUAL ALLOW	51,187.09
NON-COVERED CHARGES	10,249.50	TOTAL MEDICAID LIAB	367,883.44
		LESS: COB	367,883.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 60

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	139	0	49,500.00	9,400.00
NURSERY CARE CHARGES	4	0	1,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	143	0	50,700.00	9,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	17	0	15,290.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	15,290.00	0.00
TOTAL ACCOMODATIONS	160	0	65,990.00	9,400.00

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,945.74	0.00
MED/SURG SUPPLY	87,418.83	0.00
LABORATORY-GENERAL	32,332.21	0.00
RADIOLOGY-DIAGNOSTIC	6,869.75	0.00
CT SCAN	3,749.50	0.00
PHYSICAL THERAPY	820.25	0.00
EKG/ECG	744.75	0.00
IV THERAPY	8,000.00	0.00
OPERATING ROOM	16,711.50	0.00
LABOR/DELIVERY ROOM	57,210.25	0.00
RESPIRATORY SERVICES	28,236.50	0.00
ANESTHESIA	5,040.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,491.00	0.00
RECOVERY ROOM	7,961.25	0.00
LABORATORY PATHOLOGIC	2,286.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	300.75	0.00
SPEECH PATHOLOGY	248.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,838.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	680.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	137.25	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,380.00	169.00
OTHER LAB SERVICES	4,357.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	353,080.53	849.50
TOTAL ACCOMODATIONS	65,990.00	9,400.00
TOTAL CHARGES	419,070.53	10,249.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,717,919.85	ADJUSTMENTS	22,169.16
COVERED CHARGES	4,467,544.45	CONTRACTUAL ALLOW	2,213,896.28
NON-COVERED CHARGES	250,375.40	TOTAL MEDICAID LIAB	2,253,648.17
		LESS: COB	5,754.89
		LESS: COPAYMENT	6,048.00
		REIMBURSEMENT	2,241,845.28
		ALL OTHER	2,133,183.52
		FEE SCHEDULE-LAB	105,046.80
		INJECTABLE DRUGS	3,614.96

TOTAL NUMBER OF CLAIMS 6,755

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,023.61	20,627.76
MED/SURG SUPPLY	665,284.26	10,736.33
LABORATORY-GENERAL	0.00	16,390.97
RADIOLOGY-DIAGNOSTIC	267,527.44	13,925.72
CT SCAN	300,422.25	7,524.75
PHYSICAL THERAPY	106,449.75	7,120.25
EKG/ECG	19,875.00	0.00
IV THERAPY	57,992.66	640.00
OPERATING ROOM	260,151.54	53,677.41
LABOR/DELIVERY ROOM	187,199.97	2,233.73
RESPIRATORY SERVICES	86,932.75	2,568.50
ANESTHESIA	66,669.25	1,460.25
GI SERVICES	1,475.00	1,342.00
EMERGENCY ROOM	656,447.23	2,976.75
RECOVERY ROOM	179,324.75	4,378.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	38,264.05	3,910.75
SPEECH PATHOLOGY	59,336.75	3,125.25
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	91,801.21	4,222.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,046.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	32,259.00	370.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	374.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,148.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	299,199.39	6,542.61
OTHER LAB SERVICES	47,009.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	463,023.05	56,190.94
MRI SERVICES	204,237.90	2,059.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,115.89	25,305.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,467,544.45	250,375.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,467,544.45	250,375.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	196,558.92	ADJUSTMENTS	0.00
COVERED CHARGES	184,674.62	CONTRACTUAL ALLOW	16,953.33
NON-COVERED CHARGES	11,884.30	TOTAL MEDICAID LIAB	167,721.29
		LESS: COB	167,565.29
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	0.00
		ALL OTHER	4,215.10-
		FEE SCHEDULE-LAB	4,215.10
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 252

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,990.09	374.23
MED/SURG SUPPLY	21,537.49	336.00
LABORATORY-GENERAL	0.00	735.25
RADIOLOGY-DIAGNOSTIC	6,783.25	394.25
CT SCAN	9,699.75	0.00
PHYSICAL THERAPY	17,498.40	2,411.50
EKG/ECG	515.25	0.00
IV THERAPY	3,355.00	0.00
OPERATING ROOM	7,831.50	0.00
LABOR/DELIVERY ROOM	12,407.37	90.62
RESPIRATORY SERVICES	2,581.50	55.75
ANESTHESIA	1,683.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,293.33	483.50
RECOVERY ROOM	4,177.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,946.00	447.50
SPEECH PATHOLOGY	17,823.10	474.50
RENAL DIALYSIS	0.00	460.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,393.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,527.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	393.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,510.74	402.00
OTHER LAB SERVICES	290.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,556.10	3,003.83
MRI SERVICES	3,374.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33.00	681.37
HOME HEALTH SERVICES	0.00	7.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	184,674.62	11,884.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	184,674.62	11,884.30

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	189,224.28	ADJUSTMENTS	247.00
COVERED CHARGES	181,819.04	CONTRACTUAL ALLOW	143,587.04
NON-COVERED CHARGES	7,405.24	TOTAL MEDICAID LIAB	38,232.00
		LESS: COB	88.41
		LESS: COPAYMENT	567.00
		REIMBURSEMENT	37,576.59

TOTAL NUMBER OF CLAIMS 766

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,408.75	36.57
MED/SURG SUPPLY	2,218.54	0.00
LABORATORY-GENERAL	18,154.50	2,192.25
RADIOLOGY-DIAGNOSTIC	13,346.75	417.75
CT SCAN	8,073.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,468.50	0.00
IV THERAPY	1,020.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,944.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	114,755.25	45.75
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,446.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,401.75	0.00
OTHER LAB SERVICES	581.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,712.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	181,819.04	7,405.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	181,819.04	7,405.24

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,514.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,389.65	CONTRACTUAL ALLOW	615.28
NON-COVERED CHARGES	124.43	TOTAL MEDICAID LIAB	1,774.37
		LESS: COB	1,765.37
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175.90	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	329.00	48.50
RADIOLOGY-DIAGNOSTIC	157.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,727.75	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	75.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,389.65	124.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,389.65	124.43

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	165,291.73	ADJUSTMENTS	0.00
COVERED CHARGES	162,878.13	CONTRACTUAL ALLOW	90,241.11
NON-COVERED CHARGES	2,413.60	TOTAL MEDICAID LIAB	72,637.02
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	72,613.02

TOTAL NUMBER OF CLAIMS 18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,720.20	1,370.10
MED/SURG SUPPLY	74,141.13	0.00
LABORATORY-GENERAL	0.00	52.00
RADIOLOGY-DIAGNOSTIC	2,093.50	568.50
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	133.50	0.00
IV THERAPY	640.00	0.00
OPERATING ROOM	29,645.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	372.75	93.75
ANESTHESIA	4,168.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	12,539.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	580.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,980.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,017.50	329.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,846.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	162,878.13	2,413.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	162,878.13	2,413.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,219,452.63	ADJUSTMENTS	273,269.70
COVERED CHARGES	6,140,472.13	CONTRACTUAL ALLOW	3,207,696.17
NON-COVERED CHARGES	78,980.50	TOTAL MEDICAID LIAB	2,932,775.96
		LESS: COB	19,924.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,912,851.76

TOTAL NUMBER OF ADMISSIONS 1,076

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,613	0	637,580.02	59,370.00
NURSERY CARE CHARGES	764	0	236,930.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,377	0	874,510.02	59,370.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	223	4	201,980.00	2,460.00
N I C U	0	0	0.00	0.00
PED I C U	4	0	2,460.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	227	4	204,440.00	2,460.00
TOTAL ACCOMODATIONS	2,604	4	1,078,950.02	61,830.00

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	975,345.83	0.00
MED/SURG SUPPLY	1,340,718.29	0.00
LABORATORY-GENERAL	567,799.23	0.00
RADIOLOGY-DIAGNOSTIC	92,110.75	0.00
CT SCAN	130,364.25	0.00
PHYSICAL THERAPY	16,939.50	0.00
EKG/ECG	14,434.75	0.00
IV THERAPY	98,760.00	0.00
OPERATING ROOM	212,628.25	0.00
LABOR/DELIVERY ROOM	627,730.14	0.00
RESPIRATORY SERVICES	335,120.75	0.00
ANESTHESIA	62,464.50	0.00
GI SERVICES	1,519.50	0.00
EMERGENCY ROOM	58,406.50	0.00
RECOVERY ROOM	114,974.50	0.00
LABORATORY PATHOLOGIC	30,108.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	254.50	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	6,158.75	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,973.25	0.00
BLOOD	1,306.25	0.00
BLOOD STORAGE & PRO.	150.00	12,672.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,287.75	0.00
AUDIOLOGY	16,169.75	0.00
CARDIOLOGY	709.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	810.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	269,403.40	3,697.50
OTHER LAB SERVICES	22,193.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,551.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	780.75
INJECTABLE DRUGS	15,127.27	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,061,522.11	17,150.50
TOTAL ACCOMODATIONS	1,078,950.02	61,830.00
TOTAL CHARGES	6,140,472.13	78,980.50

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	400,694.86	ADJUSTMENTS	0.00
COVERED CHARGES	395,768.11	CONTRACTUAL ALLOW	37,652.71
NON-COVERED CHARGES	4,926.75	TOTAL MEDICAID LIAB	358,115.40
		LESS: COB	358,115.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	98	0	38,890.00	3,660.00
NURSERY CARE CHARGES	3	0	930.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	101	0	39,820.00	3,660.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	24	0	18,800.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	13	0	7,995.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	37	0	26,795.00	0.00
TOTAL ACCOMODATIONS	138	0	66,615.00	3,660.00

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,524.45	0.00
MED/SURG SUPPLY	88,558.07	0.00
LABORATORY-GENERAL	28,656.00	0.00
RADIOLOGY-DIAGNOSTIC	3,170.00	0.00
CT SCAN	3,082.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	354.75	0.00
IV THERAPY	6,805.00	0.00
OPERATING ROOM	17,867.50	0.00
LABOR/DELIVERY ROOM	42,008.75	0.00
RESPIRATORY SERVICES	43,694.00	0.00
ANESTHESIA	6,062.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,250.75	0.00
RECOVERY ROOM	8,582.50	0.00
LABORATORY PATHOLOGIC	2,025.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	598.25	0.00
BLOOD	237.50	0.00
BLOOD STORAGE & PRO.	0.00	1,049.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	47.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	405.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,855.71	217.50
OTHER LAB SERVICES	1,196.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,158.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,012.13	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	329,153.11	1,266.75
TOTAL ACCOMODATIONS	66,615.00	3,660.00
TOTAL CHARGES	395,768.11	4,926.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,395,975.48	ADJUSTMENTS	9,753.44
COVERED CHARGES	5,093,834.88	CONTRACTUAL ALLOW	2,769,211.47
NON-COVERED CHARGES	302,140.60	TOTAL MEDICAID LIAB	2,324,623.41
		LESS: COB	4,230.72
		LESS: COPAYMENT	3,174.00
		REIMBURSEMENT	2,317,218.69
		ALL OTHER	2,166,455.61
		FEE SCHEDULE-LAB	133,937.11
		INJECTABLE DRUGS	16,825.97

TOTAL NUMBER OF CLAIMS 7,326

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	369,541.60	45,380.50
MED/SURG SUPPLY	661,313.92	49,840.67
LABORATORY-GENERAL	0.00	9,257.00
RADIOLOGY-DIAGNOSTIC	277,660.25	8,565.75
CT SCAN	442,088.50	5,313.50
PHYSICAL THERAPY	123,028.50	1,282.50
EKG/ECG	30,626.75	0.00
IV THERAPY	66,195.70	320.00
OPERATING ROOM	282,050.96	33,074.63
LABOR/DELIVERY ROOM	251,409.86	516.86
RESPIRATORY SERVICES	92,768.25	1,214.50
ANESTHESIA	66,224.75	8,874.00
GI SERVICES	21,780.00	1,382.50
EMERGENCY ROOM	703,304.37	681.00
RECOVERY ROOM	162,038.50	22,067.75
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	30,314.00	934.25
SPEECH PATHOLOGY	83,989.25	831.25
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	139,897.00	6,870.25
BLOOD	712.50	0.00
BLOOD STORAGE & PRO.	300.00	5,294.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	66,286.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,615.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,863.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	315,061.17	10,676.49
OTHER LAB SERVICES	71,770.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	575,989.10	84,111.29
MRI SERVICES	216,949.75	3,279.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	32.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	315.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,055.70	2,024.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,093,834.88	302,140.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,093,834.88	302,140.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	213,443.80	ADJUSTMENTS	0.00
COVERED CHARGES	195,624.18	CONTRACTUAL ALLOW	20,554.65
NON-COVERED CHARGES	17,819.62	TOTAL MEDICAID LIAB	175,069.53
		LESS: COB	174,967.53
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	6,220.76-
		FEE SCHEDULE-LAB	5,852.59
		INJECTABLE DRUGS	368.17

TOTAL NUMBER OF CLAIMS 267

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,673.60	962.24
MED/SURG SUPPLY	25,901.59	4,373.63
LABORATORY-GENERAL	0.00	606.50
RADIOLOGY-DIAGNOSTIC	8,449.50	161.75
CT SCAN	10,406.75	0.00
PHYSICAL THERAPY	12,867.75	918.50
EKG/ECG	1,100.00	0.00
IV THERAPY	2,140.00	85.00
OPERATING ROOM	10,274.75	4,860.00
LABOR/DELIVERY ROOM	10,793.62	0.00
RESPIRATORY SERVICES	1,683.25	0.00
ANESTHESIA	3,716.00	0.00
GI SERVICES	1,451.50	0.00
EMERGENCY ROOM	18,756.00	200.00
RECOVERY ROOM	8,305.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,314.00	0.00
SPEECH PATHOLOGY	3,983.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,258.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	604.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,843.84	34.25
OTHER LAB SERVICES	3,475.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,062.16	4,748.50
MRI SERVICES	6,754.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	116.25
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	808.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	753.00

TOTAL ANCILLARY	195,624.18	17,819.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	195,624.18	17,819.62

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	207,402.02	ADJUSTMENTS	178.04
COVERED CHARGES	204,455.83	CONTRACTUAL ALLOW	160,598.83
NON-COVERED CHARGES	2,946.19	TOTAL MEDICAID LIAB	43,857.00
		LESS: COB	194.16
		LESS: COPAYMENT	627.00
		REIMBURSEMENT	43,035.84

TOTAL NUMBER OF CLAIMS 879

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,485.41	0.00
MED/SURG SUPPLY	1,749.78	0.00
LABORATORY-GENERAL	16,610.50	1,848.25
RADIOLOGY-DIAGNOSTIC	11,297.75	572.75
CT SCAN	12,213.75	0.00
PHYSICAL THERAPY	124.00	112.00
EKG/ECG	1,375.00	0.00
IV THERAPY	1,360.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	660.00	0.00
RESPIRATORY SERVICES	1,213.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	126,221.15	156.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	356.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,637.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	700.00	0.00
OTHER LAB SERVICES	461.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	66.00
MRI SERVICES	6,754.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,235.24	191.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	204,455.83	2,946.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	204,455.83	2,946.19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,317.87	ADJUSTMENTS	0.00
COVERED CHARGES	9,275.87	CONTRACTUAL ALLOW	2,344.93
NON-COVERED CHARGES	42.00	TOTAL MEDICAID LIAB	6,930.94
		LESS: COB	6,915.94
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	486.26	0.00
MED/SURG SUPPLY	62.00	0.00
LABORATORY-GENERAL	956.75	42.00
RADIOLOGY-DIAGNOSTIC	261.50	0.00
CT SCAN	1,930.50	0.00
PHYSICAL THERAPY	752.00	0.00
EKG/ECG	137.50	0.00
IV THERAPY	85.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,093.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	263.62	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	247.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,275.87	42.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,275.87	42.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	242,389.12	ADJUSTMENTS	0.00
COVERED CHARGES	232,291.10	CONTRACTUAL ALLOW	136,285.80
NON-COVERED CHARGES	10,098.02	TOTAL MEDICAID LIAB	96,005.30
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	95,966.30

TOTAL NUMBER OF CLAIMS 24

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,992.00	5,227.77
MED/SURG SUPPLY	92,753.04	927.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,162.25	1,470.25
CT SCAN	4,908.00	0.00
PHYSICAL THERAPY	0.00	217.50
EKG/ECG	550.00	0.00
IV THERAPY	480.00	0.00
OPERATING ROOM	27,217.75	0.00
LABOR/DELIVERY ROOM	7,039.00	0.00
RESPIRATORY SERVICES	2,307.50	143.50
ANESTHESIA	4,974.00	217.25
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	16,287.50	504.25
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	872.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	475.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	51,827.87	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,777.50	915.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	142.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	232,291.10	10,098.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	232,291.10	10,098.02

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,270.35	ADJUSTMENTS	0.00
COVERED CHARGES	8,270.35	CONTRACTUAL ALLOW	1,323.70
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	6,946.65
		LESS: COB	6,946.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	784.21	0.00
MED/SURG SUPPLY	5,194.90	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	934.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00
ANESTHESIA	217.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	415.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	411.62	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	245.75	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,270.35	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,270.35	0.00

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,336,968.74	ADJUSTMENTS	43,003.51
COVERED CHARGES	6,245,918.64	CONTRACTUAL ALLOW	3,301,967.58
NON-COVERED CHARGES	91,050.10	TOTAL MEDICAID LIAB	2,943,951.06
		LESS: COB	12,999.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,930,951.39

TOTAL NUMBER OF ADMISSIONS 1,109

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,510	0	602,520.00	81,210.00
NURSERY CARE CHARGES	713	0	231,800.00	250.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,223	0	834,320.00	81,460.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	314	3	292,255.00	1,890.00
N I C U	0	0	0.00	0.00
PED I C U	3	0	1,890.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	317	3	294,145.00	1,890.00
TOTAL ACCOMODATIONS	2,540	3	1,128,465.00	83,350.00

INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	918,290.99	0.00
MED/SURG SUPPLY	1,393,957.08	0.00
LABORATORY-GENERAL	530,908.13	0.00
RADIOLOGY-DIAGNOSTIC	73,768.00	0.00
CT SCAN	141,790.50	0.00
PHYSICAL THERAPY	17,981.25	0.00
EKG/ECG	14,478.50	0.00
IV THERAPY	97,385.00	0.00
OPERATING ROOM	219,368.00	0.00
LABOR/DELIVERY ROOM	712,392.37	0.00
RESPIRATORY SERVICES	324,393.50	0.00
ANESTHESIA	65,486.00	0.00
GI SERVICES	3,989.50	0.00
EMERGENCY ROOM	60,474.00	0.00
RECOVERY ROOM	115,839.75	0.00
LABORATORY PATHOLOGIC	22,500.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	10,295.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,528.50	0.00
BLOOD	1,230.00	0.00
BLOOD STORAGE & PRO.	8,064.00	775.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,263.25	0.00
AUDIOLOGY	18,281.25	0.00
CARDIOLOGY	1,804.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	839.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	256,262.18	4,140.00
OTHER LAB SERVICES	10,767.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	19,734.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,096.10
INJECTABLE DRUGS	43,381.14	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	689.00

TOTAL ANCILLARY	5,117,453.64	7,700.10
TOTAL ACCOMODATIONS	1,128,465.00	83,350.00
TOTAL CHARGES	6,245,918.64	91,050.10

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	361,177.54	ADJUSTMENTS	0.00
COVERED CHARGES	354,200.29	CONTRACTUAL ALLOW	22,557.88
NON-COVERED CHARGES	6,977.25	TOTAL MEDICAID LIAB	331,642.41
		LESS: COB	331,642.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	113	0	45,200.00	6,060.00
NURSERY CARE CHARGES	4	0	1,300.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	117	0	46,500.00	6,060.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	13	0	9,755.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	13	0	9,755.00	0.00
TOTAL ACCOMODATIONS	130	0	56,255.00	6,060.00

ZERO PAID INPATIENT PAID CLAIMS

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,261.02	0.00
MED/SURG SUPPLY	107,432.13	0.00
LABORATORY-GENERAL	22,872.95	0.00
RADIOLOGY-DIAGNOSTIC	4,038.50	0.00
CT SCAN	11,523.00	0.00
PHYSICAL THERAPY	891.50	0.00
EKG/ECG	367.50	0.00
IV THERAPY	5,760.00	0.00
OPERATING ROOM	17,787.00	0.00
LABOR/DELIVERY ROOM	21,890.50	0.00
RESPIRATORY SERVICES	16,656.84	0.00
ANESTHESIA	3,888.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,246.75	0.00
RECOVERY ROOM	6,331.50	0.00
LABORATORY PATHOLOGIC	1,278.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	651.50	0.00
BLOOD	492.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	97.50	0.00
CARDIOLOGY	250.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,976.27	225.00
OTHER LAB SERVICES	947.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	692.25
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,304.33	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	297,945.29	917.25
TOTAL ACCOMODATIONS	56,255.00	6,060.00
TOTAL CHARGES	354,200.29	6,977.25

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,141,779.72	ADJUSTMENTS	17,003.64
COVERED CHARGES	4,862,461.85	CONTRACTUAL ALLOW	2,844,378.52
NON-COVERED CHARGES	279,317.87	TOTAL MEDICAID LIAB	2,018,083.33
		LESS: COB	2,645.89
		LESS: COPAYMENT	4,062.00
		REIMBURSEMENT	2,011,375.44
		ALL OTHER	1,867,588.91
		FEE SCHEDULE-LAB	123,277.15
		INJECTABLE DRUGS	20,509.38

TOTAL NUMBER OF CLAIMS 6,859

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388,237.97	1,412.27
MED/SURG SUPPLY	662,560.38	15,583.93
LABORATORY-GENERAL	0.00	6,726.75
RADIOLOGY-DIAGNOSTIC	271,060.00	12,165.25
CT SCAN	435,161.25	32,675.00
PHYSICAL THERAPY	101,286.50	4,111.25
EKG/ECG	30,370.50	1,707.00
IV THERAPY	63,236.46	9,655.00
OPERATING ROOM	234,938.44	19,407.81
LABOR/DELIVERY ROOM	201,982.86	901.37
RESPIRATORY SERVICES	88,881.00	6,284.75
ANESTHESIA	58,971.50	180.25
GI SERVICES	19,215.50	0.00
EMERGENCY ROOM	677,694.75	35,553.00
RECOVERY ROOM	150,311.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	34,681.25	565.50
SPEECH PATHOLOGY	69,405.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	122,618.75	1,724.50
BLOOD	1,722.00	0.00
BLOOD STORAGE & PRO.	1,676.25	2,740.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	76,725.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,544.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,775.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	372,714.95	1,659.31
OTHER LAB SERVICES	36,135.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	540,437.49	96,371.50
MRI SERVICES	169,397.50	24,145.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	63.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,718.80	2,851.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,832.86

TOTAL ANCILLARY	4,862,461.85	279,317.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,862,461.85	279,317.87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	169,362.59	ADJUSTMENTS	0.00
COVERED CHARGES	148,563.09	CONTRACTUAL ALLOW	12,494.72
NON-COVERED CHARGES	20,799.50	TOTAL MEDICAID LIAB	136,068.37
		LESS: COB	135,999.37
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00
		ALL OTHER	5,077.86-
		FEE SCHEDULE-LAB	4,469.51
		INJECTABLE DRUGS	608.35

TOTAL NUMBER OF CLAIMS 227

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,874.44	0.00
MED/SURG SUPPLY	28,192.13	430.75
LABORATORY-GENERAL	0.00	321.50
RADIOLOGY-DIAGNOSTIC	7,089.25	1,829.00
CT SCAN	3,239.25	5,188.50
PHYSICAL THERAPY	363.25	0.00
EKG/ECG	652.00	284.50
IV THERAPY	1,460.00	320.00
OPERATING ROOM	10,778.50	3,673.00
LABOR/DELIVERY ROOM	9,543.00	0.00
RESPIRATORY SERVICES	2,050.50	241.25
ANESTHESIA	3,498.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,220.21	1,344.00
RECOVERY ROOM	8,165.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,403.25	0.00
SPEECH PATHOLOGY	0.00	505.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,559.50	1,191.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,492.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,823.32	629.25
OTHER LAB SERVICES	934.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,444.88	4,510.25
MRI SERVICES	4,389.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	330.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,389.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	148,563.09	20,799.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,563.09	20,799.50

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	352,679.58	ADJUSTMENTS	97.00
COVERED CHARGES	334,366.59	CONTRACTUAL ALLOW	274,705.97
NON-COVERED CHARGES	18,312.99	TOTAL MEDICAID LIAB	59,660.62
		LESS: COB	180.76
		LESS: COPAYMENT	990.00
		REIMBURSEMENT	58,489.86

TOTAL NUMBER OF CLAIMS 1,192

OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,150.25	356.98
MED/SURG SUPPLY	9,471.94	26.00
LABORATORY-GENERAL	43,832.50	5,322.25
RADIOLOGY-DIAGNOSTIC	20,593.25	609.50
CT SCAN	15,590.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,418.25	142.25
IV THERAPY	3,840.00	745.00
OPERATING ROOM	1.00	837.00
LABOR/DELIVERY ROOM	386.50	0.00
RESPIRATORY SERVICES	4,088.75	54.75
ANESTHESIA	180.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	181,819.25	9,912.00
RECOVERY ROOM	891.75	0.00
LABORATORY PATHOLOGIC	174.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,572.50	0.00
BLOOD	246.00	0.00
BLOOD STORAGE & PRO.	51.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,952.35	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	201.20	32.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,904.85	275.26
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	334,366.59	18,312.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	334,366.59	18,312.99

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,878.16	ADJUSTMENTS	0.00
COVERED CHARGES	7,074.16	CONTRACTUAL ALLOW	4,003.07
NON-COVERED CHARGES	2,804.00	TOTAL MEDICAID LIAB	3,071.09
		LESS: COB	3,065.09
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,301.60	0.00
MED/SURG SUPPLY	519.00	0.00
LABORATORY-GENERAL	898.00	730.50
RADIOLOGY-DIAGNOSTIC	0.00	579.75
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	85.00	320.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	199.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,367.50	1,173.75
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,493.56	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	210.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,074.16	2,804.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,074.16	2,804.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	517,531.97	ADJUSTMENTS	0.00
COVERED CHARGES	503,433.04	CONTRACTUAL ALLOW	334,172.83
NON-COVERED CHARGES	14,098.93	TOTAL MEDICAID LIAB	169,260.21
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	169,071.21

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP25

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,113.22	0.00
MED/SURG SUPPLY	246,237.24	2,495.98
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,827.75	3,120.25
CT SCAN	6,923.00	0.00
PHYSICAL THERAPY	546.25	0.00
EKG/ECG	0.00	711.25
IV THERAPY	640.00	0.00
OPERATING ROOM	74,549.75	1,845.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,537.50	116.75
ANESTHESIA	11,724.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	42,528.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	780.25	335.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	56,675.79	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,869.01	5,069.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	480.53	404.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	503,433.04	14,098.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	503,433.04	14,098.93

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS CO HOSP
2003 FALLS ROAD
TOCCOA GA 30577-9700

PROVIDER NUMBER 000001834A
NUMBER OF BEDS 81
TITLE XVIII NO: HOSP25

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	358,491.91	ADJUSTMENTS	0.00
COVERED CHARGES	350,328.55	CONTRACTUAL ALLOW	49,610.59
NON-COVERED CHARGES	8,163.36	TOTAL MEDICAID LIAB	300,717.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	300,717.96

TOTAL NUMBER OF ADMISSIONS 82

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	256	0	79,380.00	305.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	256	0	79,380.00	305.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	256	0	79,380.00	305.00

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,181.60	0.00
MED/SURG SUPPLY	31,323.66	0.00
LABORATORY-GENERAL	43,983.94	0.00
RADIOLOGY-DIAGNOSTIC	12,827.63	0.00
CT SCAN	8,580.00	0.00
PHYSICAL THERAPY	3,305.00	0.00
EKG/ECG	2,178.00	0.00
IV THERAPY	880.00	0.00
OPERATING ROOM	5,952.56	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,360.57	0.00
ANESTHESIA	2,916.38	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,787.52	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,833.01	0.00
BLOOD	1,218.80	0.00
BLOOD STORAGE & PRO.	1,072.50	4,950.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,001.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,842.50	0.00
OTHER LAB SERVICES	703.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,908.36
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	270,948.55	7,858.36
TOTAL ACCOMODATIONS	79,380.00	305.00
TOTAL CHARGES	350,328.55	8,163.36

ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	897,626.96	ADJUSTMENTS	43,027.40
COVERED CHARGES	832,917.73	CONTRACTUAL ALLOW	268,228.14
NON-COVERED CHARGES	64,709.23	TOTAL MEDICAID LIAB	564,689.59
		LESS: COB	587.15
		LESS: COPAYMENT	2,085.00
		REIMBURSEMENT	562,017.44
		ALL OTHER	537,662.86
		FEE SCHEDULE-LAB	24,354.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,782

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	199,174.75	1,002.78
MED/SURG SUPPLY	40,901.50	130.63
LABORATORY-GENERAL	0.00	14,522.18
RADIOLOGY-DIAGNOSTIC	89,250.11	3,968.31
CT SCAN	23,602.00	0.00
PHYSICAL THERAPY	89,209.50	2,647.00
EKG/ECG	8,415.00	198.00
IV THERAPY	26,576.00	176.00
OPERATING ROOM	20,185.41	5,447.88
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,161.85	167.77
ANESTHESIA	4,050.76	1,270.52
GI SERVICES	4,356.00	0.00
EMERGENCY ROOM	103,334.00	82.50
RECOVERY ROOM	13,853.28	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,069.15	6,545.00
BLOOD	825.00	0.00
BLOOD STORAGE & PRO.	165.00	1,402.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,059.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,988.86	847.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	59,809.50	687.50
OTHER LAB SERVICES	9,685.46	634.79
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	264.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	113,981.60	23,033.87
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	55.00

TOTAL ANCILLARY	832,917.73	62,819.23
TOTAL ACCOMODATIONS	0.00	1,890.00
TOTAL CHARGES	832,917.73	64,709.23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1.38	ADJUSTMENTS	0.00
COVERED CHARGES	1.38	CONTRACTUAL ALLOW	1.62-
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	1.38	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1.38	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1.38	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	46,046.62	ADJUSTMENTS	200.00
COVERED CHARGES	44,981.55	CONTRACTUAL ALLOW	34,431.55
NON-COVERED CHARGES	1,065.07	TOTAL MEDICAID LIAB	10,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	10,322.00

TOTAL NUMBER OF CLAIMS 211

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,379.97	0.00
MED/SURG SUPPLY	1,052.16	0.00
LABORATORY-GENERAL	4,222.57	396.00
RADIOLOGY-DIAGNOSTIC	3,013.10	514.88
CT SCAN	2,145.00	0.00
PHYSICAL THERAPY	1,543.00	0.00
EKG/ECG	99.00	0.00
IV THERAPY	880.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,627.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	96.19
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	58.00

TOTAL ANCILLARY	44,981.55	1,065.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,981.55	1,065.07

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	61,903.50	ADJUSTMENTS	12,096.99
COVERED CHARGES	59,355.65	CONTRACTUAL ALLOW	27,073.01
NON-COVERED CHARGES	2,547.85	TOTAL MEDICAID LIAB	32,282.64
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	32,261.64

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,567.03	0.00
MED/SURG SUPPLY	11,605.36	0.00
LABORATORY-GENERAL	0.00	2,138.46
RADIOLOGY-DIAGNOSTIC	1,103.28	409.39
CT SCAN	3,224.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	990.00	0.00
IV THERAPY	2,112.00	0.00
OPERATING ROOM	12,195.16	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15.04	0.00
ANESTHESIA	3,069.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,681.28	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,397.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,395.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	59,355.65	2,547.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,355.65	2,547.85

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	339,360.55	ADJUSTMENTS	3,783.03
COVERED CHARGES	324,223.57	CONTRACTUAL ALLOW	29,694.23
NON-COVERED CHARGES	15,136.98	TOTAL MEDICAID LIAB	294,529.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	294,529.34

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	259	0	81,300.00	1,137.50
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	259	0	81,300.00	1,137.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	259	0	81,300.00	1,137.50

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115,765.84	0.00
MED/SURG SUPPLY	28,745.72	0.00
LABORATORY-GENERAL	47,070.14	0.00
RADIOLOGY-DIAGNOSTIC	19,819.38	0.00
CT SCAN	3,217.50	0.00
PHYSICAL THERAPY	1,805.00	0.00
EKG/ECG	1,980.00	0.00
IV THERAPY	880.00	0.00
OPERATING ROOM	3,056.72	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,510.93	0.00
ANESTHESIA	2,730.81	1,794.48
GI SERVICES	726.00	0.00
EMERGENCY ROOM	176.00	0.00
RECOVERY ROOM	2,234.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,226.13	0.00
BLOOD	975.00	0.00
BLOOD STORAGE & PRO.	0.00	12,205.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,004.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	242,923.57	13,999.48
TOTAL ACCOMODATIONS	81,300.00	1,137.50
TOTAL CHARGES	324,223.57	15,136.98

ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	707,358.59	ADJUSTMENTS	23,219.22
COVERED CHARGES	669,011.87	CONTRACTUAL ALLOW	223,606.97
NON-COVERED CHARGES	38,346.72	TOTAL MEDICAID LIAB	445,404.90
		LESS: COB	302.60
		LESS: COPAYMENT	1,407.00
		REIMBURSEMENT	443,695.30
		ALL OTHER	422,629.77
		FEE SCHEDULE-LAB	21,065.53
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,533

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117,636.96	0.00
MED/SURG SUPPLY	30,763.27	0.00
LABORATORY-GENERAL	825.00	3,500.22
RADIOLOGY-DIAGNOSTIC	106,588.60	1,594.78
CT SCAN	24,138.25	0.00
PHYSICAL THERAPY	58,713.00	330.00
EKG/ECG	6,732.00	0.00
IV THERAPY	19,564.91	176.00
OPERATING ROOM	10,846.29	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,080.73	0.00
ANESTHESIA	6,931.42	0.00
GI SERVICES	726.00	0.00
EMERGENCY ROOM	109,466.50	0.00
RECOVERY ROOM	8,043.84	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,656.94	0.00
BLOOD	0.00	858.00
BLOOD STORAGE & PRO.	0.00	5,115.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,059.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,005.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,302.50	797.50
OTHER LAB SERVICES	10,549.50	15.85
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	132.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	105,198.46	25,213.87
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	82.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	51.70	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	33.00

TOTAL ANCILLARY	669,011.87	37,716.72
TOTAL ACCOMODATIONS	0.00	630.00
TOTAL CHARGES	669,011.87	38,346.72

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,785.64	ADJUSTMENTS	0.00
COVERED CHARGES	3,142.12	CONTRACTUAL ALLOW	322.33
NON-COVERED CHARGES	643.52	TOTAL MEDICAID LIAB	2,819.79
		LESS: COB	2,819.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328.65	0.00
MED/SURG SUPPLY	1,035.96	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175.63	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	979.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	176.00	0.00
OPERATING ROOM	0.00	643.52
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	446.88	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,142.12	643.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,142.12	643.52

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	43,950.67	ADJUSTMENTS	200.00
COVERED CHARGES	43,598.67	CONTRACTUAL ALLOW	33,148.67
NON-COVERED CHARGES	352.00	TOTAL MEDICAID LIAB	10,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	10,213.00

TOTAL NUMBER OF CLAIMS 209

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,541.43	0.00
MED/SURG SUPPLY	1,314.68	0.00
LABORATORY-GENERAL	3,281.45	352.00
RADIOLOGY-DIAGNOSTIC	4,451.61	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	297.00	0.00
IV THERAPY	1,056.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,656.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,598.67	352.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,598.67	352.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	34,006.08	ADJUSTMENTS	0.00
COVERED CHARGES	33,885.58	CONTRACTUAL ALLOW	14,290.02
NON-COVERED CHARGES	120.50	TOTAL MEDICAID LIAB	19,595.56
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	19,583.56

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,805.49	0.00
MED/SURG SUPPLY	7,711.09	0.00
LABORATORY-GENERAL	0.00	16.50
RADIOLOGY-DIAGNOSTIC	735.52	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	297.00	0.00
IV THERAPY	1,760.00	0.00
OPERATING ROOM	4,504.64	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37.13	0.00
ANESTHESIA	2,079.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,787.52	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,382.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	785.69	104.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,885.58	120.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,885.58	120.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	260,890.10	ADJUSTMENTS	5,392.74
COVERED CHARGES	248,092.46	CONTRACTUAL ALLOW	26,664.50
NON-COVERED CHARGES	12,797.64	TOTAL MEDICAID LIAB	221,427.96
		LESS: COB	1,623.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	219,804.46

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	219	0	68,740.00	3,332.50
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	219	0	68,740.00	3,332.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	219	0	68,740.00	3,332.50

INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,720.89	0.00
MED/SURG SUPPLY	13,486.25	0.00
LABORATORY-GENERAL	37,075.65	0.00
RADIOLOGY-DIAGNOSTIC	14,853.69	0.00
CT SCAN	6,510.00	0.00
PHYSICAL THERAPY	3,257.00	0.00
EKG/ECG	1,683.00	0.00
IV THERAPY	496.00	0.00
OPERATING ROOM	2,563.04	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	291.52	0.00
ANESTHESIA	2,948.14	1,732.64
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,681.28	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	539.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,795.00	6,682.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,452.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,050.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	179,352.46	9,465.14
TOTAL ACCOMODATIONS	68,740.00	3,332.50
TOTAL CHARGES	248,092.46	12,797.64

ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	612,523.88	ADJUSTMENTS	13,192.93
COVERED CHARGES	576,202.48	CONTRACTUAL ALLOW	202,113.72
NON-COVERED CHARGES	36,321.40	TOTAL MEDICAID LIAB	374,088.76
		LESS: COB	124.19
		LESS: COPAYMENT	816.00
		REIMBURSEMENT	373,148.57
		ALL OTHER	359,976.19
		FEE SCHEDULE-LAB	13,172.38
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,136

OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122,743.09	386.09
MED/SURG SUPPLY	33,909.17	197.58
LABORATORY-GENERAL	0.00	1,767.19
RADIOLOGY-DIAGNOSTIC	68,967.07	2,230.65
CT SCAN	9,652.50	0.00
PHYSICAL THERAPY	89,486.00	4,172.00
EKG/ECG	3,861.00	0.00
IV THERAPY	13,849.44	6,688.00
OPERATING ROOM	8,626.48	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,485.67	0.00
ANESTHESIA	6,803.50	0.00
GI SERVICES	3,630.00	0.00
EMERGENCY ROOM	91,349.50	82.50
RECOVERY ROOM	15,640.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,062.66	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,465.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,006.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,395.00	1,072.50
OTHER LAB SERVICES	1,140.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,594.60	14,142.39
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	137.50

TOTAL ANCILLARY	576,202.48	34,341.40
TOTAL ACCOMODATIONS	0.00	1,980.00
TOTAL CHARGES	576,202.48	36,321.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	713.73	ADJUSTMENTS	0.00
COVERED CHARGES	680.73	CONTRACTUAL ALLOW	276.64
NON-COVERED CHARGES	33.00	TOTAL MEDICAID LIAB	404.09
		LESS: COB	404.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	59.77-
		FEE SCHEDULE-LAB	59.77
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106.43	0.00
MED/SURG SUPPLY	5.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	275.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	293.80	33.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	680.73	33.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	680.73	33.00

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	65,461.42	ADJUSTMENTS	591.00
COVERED CHARGES	64,096.58	CONTRACTUAL ALLOW	50,546.58
NON-COVERED CHARGES	1,364.84	TOTAL MEDICAID LIAB	13,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	13,247.00

TOTAL NUMBER OF CLAIMS 271

OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,013.06	0.00
MED/SURG SUPPLY	1,274.12	0.00
LABORATORY-GENERAL	6,799.91	1,012.84
RADIOLOGY-DIAGNOSTIC	4,491.49	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	99.00	0.00
IV THERAPY	880.00	352.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	236.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	33,302.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,096.58	1,364.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,096.58	1,364.84

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	58,696.23	ADJUSTMENTS	3,451.24
COVERED CHARGES	57,877.73	CONTRACTUAL ALLOW	30,243.81
NON-COVERED CHARGES	818.50	TOTAL MEDICAID LIAB	27,633.92
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	27,606.92

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 11Z322

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,604.36	0.00
MED/SURG SUPPLY	15,696.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,103.28	166.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	495.00	0.00
IV THERAPY	1,936.00	352.00
OPERATING ROOM	9,813.68	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.75	0.00
ANESTHESIA	4,620.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	5,809.44	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,217.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,523.96	300.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	57,877.73	818.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,877.73	818.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSP
300 ALSTON ST
RICHLAND GA 31825-1406

PROVIDER NUMBER 000001845A
NUMBER OF BEDS 31
TITLE XVIII NO: 11Z322

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,085,926.34	ADJUSTMENTS	113,479.65
COVERED CHARGES	12,816,390.46	CONTRACTUAL ALLOW	7,107,421.76
NON-COVERED CHARGES	269,535.88	TOTAL MEDICAID LIAB	5,708,968.70
		LESS: COB	41,670.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,667,298.60

TOTAL NUMBER OF ADMISSIONS 1,875

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,912	0	1,451,450.00	127,410.00
NURSERY CARE CHARGES	1,475	0	531,160.00	13,090.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,387	0	1,982,610.00	140,500.00
SPECIAL CARE SERVICES				
C C U	333	0	289,710.00	0.00
I C U	57	0	29,925.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	390	0	319,635.00	0.00
TOTAL ACCOMODATIONS	5,777	0	2,302,245.00	140,500.00

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,812,123.76	0.00
MED/SURG SUPPLY	1,375,449.97	1,072.78
LABORATORY-GENERAL	2,113,863.86	2,021.98
RADIOLOGY-DIAGNOSTIC	195,205.97	0.00
CT SCAN	185,714.21	21,987.91
PHYSICAL THERAPY	53,189.58	0.00
EKG/ECG	41,856.38	0.00
IV THERAPY	548,123.11	0.00
OPERATING ROOM	236,122.02	0.00
LABOR/DELIVERY ROOM	814,816.22	0.00
RESPIRATORY SERVICES	360,594.13	0.00
ANESTHESIA	142,983.33	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	118,591.74	0.00
RECOVERY ROOM	97,293.93	0.00
LABORATORY PATHOLOGIC	127,289.09	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,926.18	0.00
SPEECH PATHOLOGY	6,020.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	575.60
PSYCHIATRIC SERVICES	679.88	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	102,688.15	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	61,204.04	1,380.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,724.66	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	78,700.35	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,857.56	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	249,598.43	135.52
OTHER LAB SERVICES	23,492.16	0.00
RECREATIONAL THERAPY	339.94	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	16,039.32	81,206.93
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	38,325.69	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	10,313.48
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	9,395.20
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	678,331.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	946.48

TOTAL ANCILLARY	10,514,145.46	129,035.88
TOTAL ACCOMODATIONS	2,302,245.00	140,500.00
TOTAL CHARGES	12,816,390.46	269,535.88

ZERO PAID INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,152,027.27	ADJUSTMENTS	110,308.85
COVERED CHARGES	10,176,796.44	CONTRACTUAL ALLOW	6,132,004.50
NON-COVERED CHARGES	975,230.83	TOTAL MEDICAID LIAB	4,044,791.94
		LESS: COB	4,913.50
		LESS: COPAYMENT	13,593.00
		REIMBURSEMENT	4,026,285.44
		ALL OTHER	3,752,898.74
		FEE SCHEDULE-LAB	258,301.29
		INJECTABLE DRUGS	15,085.41

TOTAL NUMBER OF CLAIMS 11,969

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,068,770.72	13,932.92
MED/SURG SUPPLY	516,734.55	4,701.88
LABORATORY-GENERAL	1,130.26	35,775.22
RADIOLOGY-DIAGNOSTIC	634,335.12	38,494.14
CT SCAN	565,195.88	47,422.25
PHYSICAL THERAPY	152,259.50	11,336.23
EKG/ECG	66,862.76	90.97
IV THERAPY	1,335,383.09	77,171.03
OPERATING ROOM	451,702.92	27,547.15
LABOR/DELIVERY ROOM	62,208.93	497.82
RESPIRATORY SERVICES	66,890.99	1,952.74
ANESTHESIA	86,621.16	802.94
GI SERVICES	859.83	0.00
EMERGENCY ROOM	879,130.74	1,455.00
RECOVERY ROOM	106,546.69	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	18,703.53	1,033.05
OCCUPATIONAL THERAPY	43,413.69	2,224.60
SPEECH PATHOLOGY	21,328.50	1,940.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	34,346.53	350.63
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	299,090.63	6,543.84
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	12,323.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	87,936.29	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	90,411.38	5,295.20
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	148,352.49	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	346,857.61	19,580.88
OTHER LAB SERVICES	54,211.08	876.68
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	163,686.62	82,201.72
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,239,483.98	533,194.65
MRI SERVICES	423,406.05	1,717.72

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,891.88
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,641.63
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	210,934.92	41,054.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	180.14

TOTAL ANCILLARY	10,176,796.44	975,230.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,176,796.44	975,230.83

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,217.47	ADJUSTMENTS	0.00
COVERED CHARGES	8,451.28	CONTRACTUAL ALLOW	2,313.58
NON-COVERED CHARGES	5,766.19	TOTAL MEDICAID LIAB	6,137.70
		LESS: COB	6,128.70
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	127.91-
		FEE SCHEDULE-LAB	127.91
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,303.05	0.00
MED/SURG SUPPLY	980.16	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	998.37	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	848.68	0.00
LABOR/DELIVERY ROOM	82.97	0.00
RESPIRATORY SERVICES	486.15	0.00
ANESTHESIA	162.46	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	565.00	0.00
RECOVERY ROOM	237.26	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	75.64	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,120.96	3,951.67
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	59.57	169.97
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,521.47	1,399.07
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	238.36
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.54	7.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	8,451.28	5,766.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,451.28	5,766.19

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	536,476.62	ADJUSTMENTS	247.00
COVERED CHARGES	521,555.82	CONTRACTUAL ALLOW	450,013.32
NON-COVERED CHARGES	14,920.80	TOTAL MEDICAID LIAB	71,542.50
		LESS: COB	89.14
		LESS: COPAYMENT	1,677.00
		REIMBURSEMENT	69,776.36

TOTAL NUMBER OF CLAIMS 1,487

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,761.12	0.00
MED/SURG SUPPLY	8,603.15	767.54
LABORATORY-GENERAL	101,303.66	9,493.88
RADIOLOGY-DIAGNOSTIC	35,398.77	637.29
CT SCAN	13,567.22	911.64
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,556.32	0.00
IV THERAPY	36,015.12	0.00
OPERATING ROOM	1,898.93	0.00
LABOR/DELIVERY ROOM	82.97	0.00
RESPIRATORY SERVICES	2,757.00	0.00
ANESTHESIA	252.89	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	221,754.00	0.00
RECOVERY ROOM	491.96	0.00
LABORATORY PATHOLOGIC	250.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,947.06	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,392.65	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	23,118.09	1,779.76
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,435.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	996.30
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,969.09	334.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	521,555.82	14,920.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	521,555.82	14,920.80

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	222.71	ADJUSTMENTS	0.00
COVERED CHARGES	169.43	CONTRACTUAL ALLOW	94.99
NON-COVERED CHARGES	53.28	TOTAL MEDICAID LIAB	74.44
		LESS: COB	74.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	14.28	0.00
LABORATORY-GENERAL	0.00	53.28
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	145.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.15	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	169.43	53.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	169.43	53.28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET

AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,668,839.36	ADJUSTMENTS	12,183.33
COVERED CHARGES	3,484,592.26	CONTRACTUAL ALLOW	2,399,741.89
NON-COVERED CHARGES	184,247.10	TOTAL MEDICAID LIAB	1,084,850.37
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	1,084,628.37

TOTAL NUMBER OF CLAIMS 267

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	586,987.67	1,785.54
MED/SURG SUPPLY	119,171.80	70.70
LABORATORY-GENERAL	3,061.38	4,156.58
RADIOLOGY-DIAGNOSTIC	58,362.39	3,097.00
CT SCAN	54,014.39	4,995.00
PHYSICAL THERAPY	4,632.49	0.00
EKG/ECG	1,084.16	0.00
IV THERAPY	1,199,365.82	0.00
OPERATING ROOM	20,883.27	1,167.36
LABOR/DELIVERY ROOM	2,056.25	0.00
RESPIRATORY SERVICES	122,642.46	48.88
ANESTHESIA	5,544.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,495.74	0.00
RECOVERY ROOM	6,026.86	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	25,445.87	0.00
OCCUPATIONAL THERAPY	4,781.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,219.60	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	61,941.40	0.00
OTHER IMAGING SERVICES	11,810.78	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	6,288.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,467.64	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,844.01	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,537.32	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	216,370.51	1,656.88
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	260,596.75	83,846.18
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	290,849.47	75,355.46
MRI SERVICES	13,316.24	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	390,082.19	1,779.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,484,592.26	184,247.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,484,592.26	184,247.10

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,822,253.27	ADJUSTMENTS	83,922.62
COVERED CHARGES	14,667,882.33	CONTRACTUAL ALLOW	8,893,174.96
NON-COVERED CHARGES	154,370.94	TOTAL MEDICAID LIAB	5,774,707.37
		LESS: COB	28,388.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,746,319.00

TOTAL NUMBER OF ADMISSIONS 1,906

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,949	0	1,605,350.00	85,515.00
NURSERY CARE CHARGES	1,386	0	532,675.00	6,870.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,335	0	2,138,025.00	92,385.00
SPECIAL CARE SERVICES				
C C U	334	0	306,680.00	0.00
I C U	67	0	37,125.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	401	0	343,805.00	0.00
TOTAL ACCOMODATIONS	5,736	0	2,481,830.00	92,385.00

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,214,926.30	771.88
MED/SURG SUPPLY	1,849,988.47	1,055.36
LABORATORY-GENERAL	2,177,777.87	3,072.83
RADIOLOGY-DIAGNOSTIC	202,358.74	0.00
CT SCAN	257,541.49	0.00
PHYSICAL THERAPY	68,887.94	0.00
EKG/ECG	37,165.83	0.00
IV THERAPY	467,985.99	0.00
OPERATING ROOM	341,294.32	0.00
LABOR/DELIVERY ROOM	940,941.41	0.00
RESPIRATORY SERVICES	535,870.86	0.00
ANESTHESIA	275,523.65	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	126,705.77	0.00
RECOVERY ROOM	246,411.64	0.00
LABORATORY PATHOLOGIC	139,329.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	16,398.84	0.00
SPEECH PATHOLOGY	4,124.14	54.75
RENAL DIALYSIS	0.00	181.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	6,486.08
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,752.15	0.00
BLOOD	2,931.04	0.00
BLOOD STORAGE & PRO.	58,397.03	9,501.17
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,138.33	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	56,002.82	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,946.84	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	227,854.50	69.80
OTHER LAB SERVICES	38,582.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	59,680.94	10,784.87
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	60,662.65	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	23,590.68
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,781.36
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	664,871.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,635.46

TOTAL ANCILLARY	12,186,052.33	61,985.94
TOTAL ACCOMODATIONS	2,481,830.00	92,385.00
TOTAL CHARGES	14,667,882.33	154,370.94

ZERO PAID INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,949.91	ADJUSTMENTS	0.00
COVERED CHARGES	2,919.91	CONTRACTUAL ALLOW	917.37
NON-COVERED CHARGES	30.00	TOTAL MEDICAID LIAB	2,002.54
		LESS: COB	2,002.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	0	400.00	30.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	400.00	30.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	400.00	30.00

ZERO PAID INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	743.30	0.00
MED/SURG SUPPLY	242.76	0.00
LABORATORY-GENERAL	667.36	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	544.06	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	257.33	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,519.91	0.00
TOTAL ACCOMODATIONS	400.00	30.00
TOTAL CHARGES	2,919.91	30.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,654,180.58	ADJUSTMENTS	570,043.07
COVERED CHARGES	11,903,557.00	CONTRACTUAL ALLOW	7,943,433.66
NON-COVERED CHARGES	750,623.58	TOTAL MEDICAID LIAB	3,960,123.34
		LESS: COB	7,481.81
		LESS: COPAYMENT	7,722.00
		REIMBURSEMENT	3,944,919.53
		ALL OTHER	3,584,376.62
		FEE SCHEDULE-LAB	333,667.16
		INJECTABLE DRUGS	26,875.75

TOTAL NUMBER OF CLAIMS 12,051

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,299,488.67	11,910.91
MED/SURG SUPPLY	821,183.74	3,166.99
LABORATORY-GENERAL	1,991.85	54,193.68
RADIOLOGY-DIAGNOSTIC	710,591.87	4,781.12
CT SCAN	728,366.47	1,416.63
PHYSICAL THERAPY	215,747.66	1,454.22
EKG/ECG	86,102.26	1,035.34
IV THERAPY	1,376,623.11	896.86
OPERATING ROOM	607,469.71	13,897.67
LABOR/DELIVERY ROOM	55,637.66	301.37
RESPIRATORY SERVICES	111,398.71	3,981.32
ANESTHESIA	126,739.80	137.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	985,070.36	219.00
RECOVERY ROOM	141,858.39	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,564.79	0.00
OCCUPATIONAL THERAPY	61,628.24	1,303.52
SPEECH PATHOLOGY	36,979.92	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37,290.07	419.03
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	342,476.38	2,092.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	294.00	294.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	88,840.17	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	102,053.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	100,718.79	1,091.16
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	381,729.86	533.80
OTHER LAB SERVICES	65,321.77	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	234.80	0.00
OTHER THERAPEUTIC SERVI	251,493.26	6,438.74
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,708,780.54	565,024.61
MRI SERVICES	373,701.33	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	6,049.40
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	11,182.87
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	65.96
INJECTABLE DRUGS	73,179.26	58,015.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	720.91

TOTAL ANCILLARY	11,903,557.00	750,623.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,903,557.00	750,623.58

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,870.52	ADJUSTMENTS	0.00
COVERED CHARGES	14,082.21	CONTRACTUAL ALLOW	8,049.01
NON-COVERED CHARGES	788.31	TOTAL MEDICAID LIAB	6,033.20
		LESS: COB	6,027.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	393.12-
		FEE SCHEDULE-LAB	372.38
		INJECTABLE DRUGS	20.74

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	801.31	365.51
MED/SURG SUPPLY	1,850.57	0.00
LABORATORY-GENERAL	0.00	135.42
RADIOLOGY-DIAGNOSTIC	970.06	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,927.90	0.00
OPERATING ROOM	1,596.37	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	107.04	53.52
ANESTHESIA	285.48	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,516.60	0.00
RECOVERY ROOM	338.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	819.62	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	873.25	0.00
OTHER LAB SERVICES	701.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	131.40	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,097.71	79.38
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65.14	154.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,082.21	788.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,082.21	788.31

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	600,819.84	ADJUSTMENTS	6,965.76
COVERED CHARGES	583,589.92	CONTRACTUAL ALLOW	508,029.30
NON-COVERED CHARGES	17,229.92	TOTAL MEDICAID LIAB	75,560.62
		LESS: COB	114.11
		LESS: COPAYMENT	1,737.00
		REIMBURSEMENT	73,709.51

TOTAL NUMBER OF CLAIMS 1,566

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,933.05	0.00
MED/SURG SUPPLY	19,196.59	452.88
LABORATORY-GENERAL	105,471.14	7,095.58
RADIOLOGY-DIAGNOSTIC	58,768.41	0.00
CT SCAN	20,323.11	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,714.58	0.00
IV THERAPY	28,355.48	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	179.65	0.00
RESPIRATORY SERVICES	6,411.96	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	251,925.84	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	176.90	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,942.83	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,956.03	0.00
OTHER LAB SERVICES	1,757.49	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	28,877.70	1,146.66
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,727.38	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,516.12
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,871.78	7,018.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	583,589.92	17,229.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	583,589.92	17,229.92

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,001.60	ADJUSTMENTS	0.00
COVERED CHARGES	1,001.60	CONTRACTUAL ALLOW	595.14
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	406.46
		LESS: COB	406.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192.62	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	536.56	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	262.80	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,001.60	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,001.60	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET

AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,771,880.81	ADJUSTMENTS	195,922.79
COVERED CHARGES	3,655,474.75	CONTRACTUAL ALLOW	2,626,109.87
NON-COVERED CHARGES	116,406.06	TOTAL MEDICAID LIAB	1,029,364.88
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	1,029,226.88

TOTAL NUMBER OF CLAIMS 257

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	767,123.45	169.07
MED/SURG SUPPLY	216,959.62	58.00
LABORATORY-GENERAL	2,654.70	4,322.53
RADIOLOGY-DIAGNOSTIC	46,217.18	331.37
CT SCAN	39,915.39	0.00
PHYSICAL THERAPY	6,590.24	0.00
EKG/ECG	1,679.73	445.17
IV THERAPY	1,241,527.15	0.00
OPERATING ROOM	72,719.92	0.00
LABOR/DELIVERY ROOM	1,796.50	0.00
RESPIRATORY SERVICES	112,107.70	3,419.18
ANESTHESIA	19,213.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,019.84	0.00
RECOVERY ROOM	22,571.54	527.68
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	24,559.60	520.40
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,445.96	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,129.63	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,635.96
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,462.17	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,956.89	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,228.94	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	194,305.44	0.00
OTHER LAB SERVICES	363.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	361,446.46	497.65
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	446,065.73	79,366.87
MRI SERVICES	2,964.13	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,450.04	24,112.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,655,474.75	116,406.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,655,474.75	116,406.06

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,454,639.61	ADJUSTMENTS	164,034.43
COVERED CHARGES	13,328,101.33	CONTRACTUAL ALLOW	8,280,834.84
NON-COVERED CHARGES	126,538.28	TOTAL MEDICAID LIAB	5,047,266.49
		LESS: COB	28,004.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,019,262.40

TOTAL NUMBER OF ADMISSIONS 1,745

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,257	0	1,402,675.00	75,563.60
NURSERY CARE CHARGES	1,245	0	510,905.00	3,890.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,502	0	1,913,580.00	79,453.60
SPECIAL CARE SERVICES				
C C U	262	0	255,450.00	0.00
I C U	42	0	24,780.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	304	0	280,230.00	0.00
TOTAL ACCOMODATIONS	4,806	0	2,193,810.00	79,453.60

INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,790,631.72	134.50
MED/SURG SUPPLY	1,444,928.49	127.93
LABORATORY-GENERAL	1,922,272.43	2,664.08
RADIOLOGY-DIAGNOSTIC	156,040.57	0.00
CT SCAN	224,858.32	0.00
PHYSICAL THERAPY	110,359.76	0.00
EKG/ECG	32,930.61	0.00
IV THERAPY	415,293.06	0.00
OPERATING ROOM	723,504.13	0.00
LABOR/DELIVERY ROOM	792,265.95	0.00
RESPIRATORY SERVICES	616,194.79	0.00
ANESTHESIA	377,660.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	101,207.38	0.00
RECOVERY ROOM	180,573.99	0.00
LABORATORY PATHOLOGIC	137,198.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,586.40	0.00
SPEECH PATHOLOGY	1,844.84	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	12,169.29
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	69,313.66	0.00
BLOOD	1,900.00	0.00
BLOOD STORAGE & PRO.	41,668.06	1,737.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,086.09	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	46,041.65	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,920.62	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	207,552.01	0.00
OTHER LAB SERVICES	17,304.03	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	58.70	0.00
OTHER THERAPEUTIC SERVI	61,976.00	3,050.04
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	46,188.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	21,780.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	300.89
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	568,930.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,120.15

TOTAL ANCILLARY	11,134,291.33	47,084.68
TOTAL ACCOMODATIONS	2,193,810.00	79,453.60
TOTAL CHARGES	13,328,101.33	126,538.28

ZERO PAID INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	33,517.81	ADJUSTMENTS	0.00
COVERED CHARGES	33,397.81	CONTRACTUAL ALLOW	24,522.12
NON-COVERED CHARGES	120.00	TOTAL MEDICAID LIAB	8,875.69
		LESS: COB	8,875.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4	0	1,700.00	120.00
NURSERY CARE CHARGES	2	0	820.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	2,520.00	120.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,520.00	120.00

ZERO PAID INPATIENT PAID CLAIMS

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,880.11	0.00
MED/SURG SUPPLY	11,571.60	0.00
LABORATORY-GENERAL	2,868.39	0.00
RADIOLOGY-DIAGNOSTIC	426.89	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,908.35	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,025.05	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,444.74	0.00
ANESTHESIA	1,900.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	701.10	0.00
LABORATORY PATHOLOGIC	60.17	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	82.18	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,009.23	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,877.81	0.00
TOTAL ACCOMODATIONS	2,520.00	120.00
TOTAL CHARGES	33,397.81	120.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,367,255.75	ADJUSTMENTS	288,144.86
COVERED CHARGES	12,641,461.88	CONTRACTUAL ALLOW	9,278,120.73
NON-COVERED CHARGES	725,793.87	TOTAL MEDICAID LIAB	3,363,341.15
		LESS: COB	4,994.54
		LESS: COPAYMENT	10,335.00
		REIMBURSEMENT	3,348,011.61
		ALL OTHER	2,918,801.09
		FEE SCHEDULE-LAB	394,751.23
		INJECTABLE DRUGS	34,459.29

TOTAL NUMBER OF CLAIMS 11,783

OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,367,791.07	10,040.97
MED/SURG SUPPLY	611,900.79	5,644.69
LABORATORY-GENERAL	1,749.36	73,238.70
RADIOLOGY-DIAGNOSTIC	626,589.67	1,559.99
CT SCAN	741,424.01	5,878.78
PHYSICAL THERAPY	205,949.86	1,324.86
EKG/ECG	75,447.13	0.00
IV THERAPY	1,308,478.83	9,431.66
OPERATING ROOM	970,446.25	9,141.69
LABOR/DELIVERY ROOM	65,954.74	118.47
RESPIRATORY SERVICES	116,897.00	5,376.06
ANESTHESIA	465,080.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	899,274.70	401.05
RECOVERY ROOM	217,139.74	485.00
LABORATORY PATHOLOGIC	0.00	152.06
RADIOLOGY THERAPEUTIC	46,849.98	0.00
OCCUPATIONAL THERAPY	64,582.93	149.60
SPEECH PATHOLOGY	10,073.53	62.96
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	18,723.25	55,380.23
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	376,953.91	2,364.92
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,101.82	12,268.20
ONCOLOGY	930.60	0.00
NUCLEAR MEDICINE	87,866.17	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	50,410.52	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	94,599.58	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	409,085.63	6,240.66
OTHER LAB SERVICES	74,867.74	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	270.04	337.55
OTHER THERAPEUTIC SERVI	175,011.71	14,787.31
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,957,645.23	490,055.39
MRI SERVICES	477,309.32	7,956.11

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,455.91
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	112,056.77	9,685.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,255.54

TOTAL ANCILLARY	12,641,461.88	725,793.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,641,461.88	725,793.87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	12,486.03	ADJUSTMENTS	0.00
COVERED CHARGES	9,022.41	CONTRACTUAL ALLOW	6,144.83
NON-COVERED CHARGES	3,463.62	TOTAL MEDICAID LIAB	2,877.58
		LESS: COB	2,868.58
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	379.16-
		FEE SCHEDULE-LAB	376.55
		INJECTABLE DRUGS	2.61

TOTAL NUMBER OF CLAIMS 13

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210.55	0.00
MED/SURG SUPPLY	169.60	0.00
LABORATORY-GENERAL	0.00	340.63
RADIOLOGY-DIAGNOSTIC	751.26	0.00
CT SCAN	1,124.24	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,831.77	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	104.48	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	367.31	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	226.46
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,453.50	1,581.74
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,314.79
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,022.41	3,463.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,022.41	3,463.62

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	947,748.61	ADJUSTMENTS	2,008.00
COVERED CHARGES	913,719.20	CONTRACTUAL ALLOW	816,106.50
NON-COVERED CHARGES	34,029.41	TOTAL MEDICAID LIAB	97,612.70
		LESS: COB	67.17
		LESS: COPAYMENT	2,760.00
		REIMBURSEMENT	94,785.53

TOTAL NUMBER OF CLAIMS 1,999

OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,268.61	182.47
MED/SURG SUPPLY	33,026.71	1,304.60
LABORATORY-GENERAL	192,873.65	13,346.74
RADIOLOGY-DIAGNOSTIC	72,400.86	0.00
CT SCAN	47,183.52	1,179.03
PHYSICAL THERAPY	598.40	0.00
EKG/ECG	6,884.91	0.00
IV THERAPY	47,747.91	1,159.72
OPERATING ROOM	16,533.52	900.00
LABOR/DELIVERY ROOM	522.40	0.00
RESPIRATORY SERVICES	5,590.80	72.48
ANESTHESIA	8,360.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	347,053.44	0.00
RECOVERY ROOM	2,962.86	0.00
LABORATORY PATHOLOGIC	1,104.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	248.14	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	72.06	10,682.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,807.44	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,213.47	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,448.74	0.00
OTHER LAB SERVICES	981.06	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	22,473.18	4,892.88
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	155.34	84.69
MRI SERVICES	2,261.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,946.24	224.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	913,719.20	34,029.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	913,719.20	34,029.41

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,323.23	ADJUSTMENTS	0.00
COVERED CHARGES	2,323.23	CONTRACTUAL ALLOW	1,683.11
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	640.12
		LESS: COB	634.12
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263.71	0.00
MED/SURG SUPPLY	129.03	0.00
LABORATORY-GENERAL	257.56	0.00
RADIOLOGY-DIAGNOSTIC	250.37	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,089.29	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	219.13	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	114.14	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,323.23	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,323.23	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET

AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,925,581.01	ADJUSTMENTS	121,676.70
COVERED CHARGES	3,801,448.99	CONTRACTUAL ALLOW	2,970,211.98
NON-COVERED CHARGES	124,132.02	TOTAL MEDICAID LIAB	831,237.01
		LESS: COB	0.00
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	830,748.01

TOTAL NUMBER OF CLAIMS 239

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0001GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	626,778.57	5,087.51
MED/SURG SUPPLY	220,463.79	2,301.79
LABORATORY-GENERAL	0.00	6,323.99
RADIOLOGY-DIAGNOSTIC	25,375.02	250.42
CT SCAN	19,194.57	0.00
PHYSICAL THERAPY	1,521.31	73.76
EKG/ECG	1,661.21	0.00
IV THERAPY	1,282,068.93	35,193.19
OPERATING ROOM	126,290.40	1,719.47
LABOR/DELIVERY ROOM	6,832.16	0.00
RESPIRATORY SERVICES	121,563.38	3,179.20
ANESTHESIA	56,560.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,334.15	0.00
RECOVERY ROOM	24,522.47	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	50,825.13	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,679.92	3,289.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,705.18	609.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,883.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,643.16	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	527.24	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	151,119.13	3,338.03
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	125,396.05	4,839.12
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	882,592.86	54,030.77
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	50,911.16	3,895.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,801,448.99	124,132.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,801,448.99	124,132.02

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICUS & SUMTER CTY. HOSP AUTH.
1048 FORSYTH STREET
AMERICUS GA 31709-3722

PROVIDER NUMBER 000000019A
NUMBER OF BEDS 140
TITLE XVIII NO: HPH0001GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	229,873.27	ADJUSTMENTS	4,699.16
COVERED CHARGES	218,501.27	CONTRACTUAL ALLOW	108,940.81
NON-COVERED CHARGES	11,372.00	TOTAL MEDICAID LIAB	109,560.46
		LESS: COB	967.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	108,592.64

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	51	37	11,475.00	8,795.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	51	37	11,475.00	8,795.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	51	37	11,475.00	8,795.00

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,827.77	0.00
MED/SURG SUPPLY	34,240.50	53.00
LABORATORY-GENERAL	49,136.50	0.00
RADIOLOGY-DIAGNOSTIC	4,585.00	0.00
CT SCAN	6,969.50	2,504.00
PHYSICAL THERAPY	1,039.50	0.00
EKG/ECG	1,365.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,033.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,893.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	179.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,002.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,195.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,988.00	0.00
OTHER LAB SERVICES	571.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	20.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	207,026.27	2,577.00
TOTAL ACCOMODATIONS	11,475.00	8,795.00
TOTAL CHARGES	218,501.27	11,372.00

ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,918,727.11	ADJUSTMENTS	9,760.02
COVERED CHARGES	1,782,199.71	CONTRACTUAL ALLOW	1,012,683.35
NON-COVERED CHARGES	136,527.40	TOTAL MEDICAID LIAB	769,516.36
		LESS: COB	2,387.95
		LESS: COPAYMENT	1,842.00
		REIMBURSEMENT	765,286.41
		ALL OTHER	722,465.31
		FEE SCHEDULE-LAB	39,987.94
		INJECTABLE DRUGS	2,833.16

TOTAL NUMBER OF CLAIMS 3,627

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,279.87	1,924.50
MED/SURG SUPPLY	82,912.00	637.50
LABORATORY-GENERAL	0.00	5,789.00
RADIOLOGY-DIAGNOSTIC	199,732.50	5,722.50
CT SCAN	33,823.50	7,416.00
PHYSICAL THERAPY	136,302.00	4,999.00
EKG/ECG	17,472.00	273.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,723.00	370.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	550,286.00	3,502.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	48,322.15	5,539.00
SPEECH PATHOLOGY	19,062.00	540.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	85,866.50	791.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	33,696.00	2,160.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	471.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	65.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,243.50	0.00
OTHER LAB SERVICES	6,281.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	385,976.16	70,110.15
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	15,843.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,221.53	10,359.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	15.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,782,199.71	136,527.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,782,199.71	136,527.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,744.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,073.00	CONTRACTUAL ALLOW	1,843.98
NON-COVERED CHARGES	671.50	TOTAL MEDICAID LIAB	4,229.02
		LESS: COB	4,226.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	105.12-
		FEE SCHEDULE-LAB	105.12
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	459.50	0.00
MED/SURG SUPPLY	133.50	0.00
LABORATORY-GENERAL	0.00	24.00
RADIOLOGY-DIAGNOSTIC	808.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,336.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,112.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	64.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,159.50	559.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	64.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	24.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,073.00	671.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,073.00	671.50

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	188,189.46	ADJUSTMENTS	147.00
COVERED CHARGES	183,657.50	CONTRACTUAL ALLOW	156,807.50
NON-COVERED CHARGES	4,531.96	TOTAL MEDICAID LIAB	26,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	26,718.00

TOTAL NUMBER OF CLAIMS 537

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,988.50	0.00
MED/SURG SUPPLY	3,900.50	53.00
LABORATORY-GENERAL	29,777.50	1,377.00
RADIOLOGY-DIAGNOSTIC	13,015.00	0.00
CT SCAN	1,217.50	1,217.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,774.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,039.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	109,120.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	136.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	795.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	893.00	1,884.46
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	183,657.50	4,531.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	183,657.50	4,531.96

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,095.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,870.50	CONTRACTUAL ALLOW	219.60
NON-COVERED CHARGES	225.00	TOTAL MEDICAID LIAB	1,650.90
		LESS: COB	1,650.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	682.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	167.00	24.00
RADIOLOGY-DIAGNOSTIC	209.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	122.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	690.50	175.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	26.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,870.50	225.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,870.50	225.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,376.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,376.00	CONTRACTUAL ALLOW	4,228.17
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	4,147.83
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,144.83

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	3,171.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,045.00	0.00
SPEECH PATHOLOGY	2,160.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,376.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,376.00	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	209,954.30	ADJUSTMENTS	3,895.53
COVERED CHARGES	208,765.05	CONTRACTUAL ALLOW	106,271.02
NON-COVERED CHARGES	1,189.25	TOTAL MEDICAID LIAB	102,494.03
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	102,494.03

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	67	0	15,075.00	1,189.25
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	15,075.00	1,189.25
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	67	0	15,075.00	1,189.25

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,677.36	0.00
MED/SURG SUPPLY	30,348.10	0.00
LABORATORY-GENERAL	42,658.25	0.00
RADIOLOGY-DIAGNOSTIC	6,050.00	0.00
CT SCAN	1,302.75	0.00
PHYSICAL THERAPY	2,894.25	0.00
EKG/ECG	292.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,367.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,392.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	256.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	511.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,760.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	179.34	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	193,690.05	0.00
TOTAL ACCOMODATIONS	15,075.00	1,189.25
TOTAL CHARGES	208,765.05	1,189.25

ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,086,237.15	ADJUSTMENTS	70,400.99
COVERED CHARGES	1,964,157.25	CONTRACTUAL ALLOW	1,130,220.72
NON-COVERED CHARGES	122,079.90	TOTAL MEDICAID LIAB	833,936.53
		LESS: COB	638.74
		LESS: COPAYMENT	1,827.00
		REIMBURSEMENT	831,470.79
		ALL OTHER	781,411.03
		FEE SCHEDULE-LAB	37,194.17
		INJECTABLE DRUGS	12,865.59

TOTAL NUMBER OF CLAIMS 3,516

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,495.57	971.75
MED/SURG SUPPLY	94,059.10	522.00
LABORATORY-GENERAL	321.00	4,384.50
RADIOLOGY-DIAGNOSTIC	210,633.50	1,513.25
CT SCAN	68,517.00	23,928.00
PHYSICAL THERAPY	160,700.80	4,491.50
EKG/ECG	14,118.00	0.00
IV THERAPY	809.25	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,260.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	609,202.55	1,800.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	32,182.75	966.50
SPEECH PATHOLOGY	15,593.50	385.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	70,248.25	974.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	33,593.25	462.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	511.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	69.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,772.00	0.00
OTHER LAB SERVICES	4,089.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	444,435.34	72,700.95
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,544.89	8,980.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,964,157.25	122,079.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,964,157.25	122,079.90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,707.25	ADJUSTMENTS	0.00
COVERED CHARGES	17,831.25	CONTRACTUAL ALLOW	11,760.30
NON-COVERED CHARGES	876.00	TOTAL MEDICAID LIAB	6,070.95
		LESS: COB	6,064.95
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	455.91-
		FEE SCHEDULE-LAB	354.21
		INJECTABLE DRUGS	101.70

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,812.50	0.00
MED/SURG SUPPLY	1,374.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,100.25	0.00
CT SCAN	1,302.75	0.00
PHYSICAL THERAPY	357.00	0.00
EKG/ECG	146.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	265.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,897.25	112.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	64.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	69.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	759.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,489.50	572.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	64.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	193.75	126.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,831.25	876.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,831.25	876.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	227,556.41	ADJUSTMENTS	1,376.03
COVERED CHARGES	220,978.73	CONTRACTUAL ALLOW	192,277.42
NON-COVERED CHARGES	6,577.68	TOTAL MEDICAID LIAB	28,701.31
		LESS: COB	0.00
		LESS: COPAYMENT	666.00
		REIMBURSEMENT	28,035.31

TOTAL NUMBER OF CLAIMS 576

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,928.00	0.00
MED/SURG SUPPLY	6,241.50	0.00
LABORATORY-GENERAL	39,275.40	3,002.75
RADIOLOGY-DIAGNOSTIC	13,622.00	171.25
CT SCAN	1,302.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,295.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,895.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	41.25	0.00
EMERGENCY ROOM	131,307.75	993.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	574.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,680.75	359.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,815.33	2,050.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	220,978.73	6,577.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	220,978.73	6,577.68

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,240.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,592.75	CONTRACTUAL ALLOW	3,303.45
NON-COVERED CHARGES	648.00	TOTAL MEDICAID LIAB	289.30
		LESS: COB	289.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	550.50	0.00
MED/SURG SUPPLY	62.75	0.00
LABORATORY-GENERAL	412.00	0.00
RADIOLOGY-DIAGNOSTIC	821.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,665.25	648.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,592.75	648.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,592.75	648.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	122,331.13	ADJUSTMENTS	0.00
COVERED CHARGES	120,346.00	CONTRACTUAL ALLOW	77,109.03
NON-COVERED CHARGES	1,985.13	TOTAL MEDICAID LIAB	43,236.97
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	43,221.97

TOTAL NUMBER OF CLAIMS 11

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,635.00	0.00
MED/SURG SUPPLY	13,863.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,065.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	23,910.25	0.00
EKG/ECG	292.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	110.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,122.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,148.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,127.00	0.00
SPEECH PATHOLOGY	5,197.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	146.25	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	130.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,032.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,244.25	1,416.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	322.00	569.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	120,346.00	1,985.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	120,346.00	1,985.13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	211,514.02	ADJUSTMENTS	0.00
COVERED CHARGES	204,011.32	CONTRACTUAL ALLOW	111,639.17
NON-COVERED CHARGES	7,502.70	TOTAL MEDICAID LIAB	92,372.15
		LESS: COB	1,852.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,519.90

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	60	0	13,500.00	7,502.70
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	13,500.00	7,502.70
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	60	0	13,500.00	7,502.70

INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,816.52	0.00
MED/SURG SUPPLY	27,968.50	0.00
LABORATORY-GENERAL	37,587.90	0.00
RADIOLOGY-DIAGNOSTIC	5,678.15	0.00
CT SCAN	5,854.30	0.00
PHYSICAL THERAPY	1,458.50	0.00
EKG/ECG	481.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,794.90	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,012.95	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	557.80	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,283.70	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,344.20	0.00
OTHER LAB SERVICES	672.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	190,511.32	0.00
TOTAL ACCOMODATIONS	13,500.00	7,502.70
TOTAL CHARGES	204,011.32	7,502.70

ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,598,804.20	ADJUSTMENTS	29,284.58
COVERED CHARGES	1,461,791.79	CONTRACTUAL ALLOW	886,491.52
NON-COVERED CHARGES	137,012.41	TOTAL MEDICAID LIAB	575,300.27
		LESS: COB	1,387.67
		LESS: COPAYMENT	1,752.00
		REIMBURSEMENT	572,160.60
		ALL OTHER	538,273.42
		FEE SCHEDULE-LAB	24,984.33
		INJECTABLE DRUGS	8,902.85

TOTAL NUMBER OF CLAIMS 1,955

OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,970.00	368.85
MED/SURG SUPPLY	64,517.90	47.30
LABORATORY-GENERAL	0.00	3,157.00
RADIOLOGY-DIAGNOSTIC	140,313.25	817.65
CT SCAN	74,875.50	41,158.90
PHYSICAL THERAPY	152,087.05	7,528.75
EKG/ECG	14,452.90	0.00
IV THERAPY	189.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,091.05	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	395,755.05	13,207.05
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	62,638.45	2,527.10
SPEECH PATHOLOGY	28,728.35	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	34,025.25	2,029.55
PSYCHIATRIC SERVICES	4,680.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,783.15	508.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	844.05
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,791.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,020.10	75.90
OTHER LAB SERVICES	4,541.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	329,917.91	61,231.62
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,413.88	3,510.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,461,791.79	137,012.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,461,791.79	137,012.41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	157.65	ADJUSTMENTS	0.00
COVERED CHARGES	157.65	CONTRACTUAL ALLOW	105.80
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	51.85
		LESS: COB	45.85
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	4.29-
		FEE SCHEDULE-LAB	0.12-
		INJECTABLE DRUGS	4.41

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	81.40	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	157.65	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	157.65	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	259,459.60	ADJUSTMENTS	1,036.59
COVERED CHARGES	246,973.75	CONTRACTUAL ALLOW	224,458.09
NON-COVERED CHARGES	12,485.85	TOTAL MEDICAID LIAB	22,515.66
		LESS: COB	0.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	22,056.66

TOTAL NUMBER OF CLAIMS 448

OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,271.30	0.00
MED/SURG SUPPLY	6,980.65	0.00
LABORATORY-GENERAL	57,681.30	2,959.90
RADIOLOGY-DIAGNOSTIC	17,478.65	0.00
CT SCAN	2,947.50	8,064.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,124.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,410.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	130,773.25	901.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	785.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	39.35	0.00
PSYCHIATRIC SERVICES	2,730.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	421.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,972.70	73.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,357.25	486.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	246,973.75	12,485.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	246,973.75	12,485.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,665.80	ADJUSTMENTS	0.00
COVERED CHARGES	8,659.95	CONTRACTUAL ALLOW	8,656.95
NON-COVERED CHARGES	2,005.85	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,796.70	0.00
MED/SURG SUPPLY	131.55	0.00
LABORATORY-GENERAL	1,171.65	0.00
RADIOLOGY-DIAGNOSTIC	938.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	160.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,210.25	1,980.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23.65	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	226.65	25.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,659.95	2,005.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,659.95	2,005.85

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	71,604.75	ADJUSTMENTS	0.00
COVERED CHARGES	69,061.75	CONTRACTUAL ALLOW	48,327.01
NON-COVERED CHARGES	2,543.00	TOTAL MEDICAID LIAB	20,734.74
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	20,701.74

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP95

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,412.15	0.00
MED/SURG SUPPLY	1,814.25	0.00
LABORATORY-GENERAL	0.00	66.00
RADIOLOGY-DIAGNOSTIC	829.75	0.00
CT SCAN	3,683.65	0.00
PHYSICAL THERAPY	2,553.20	0.00
EKG/ECG	1,603.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,730.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,828.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,100.45	59.70
SPEECH PATHOLOGY	2,329.25	211.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	390.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	76.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	311.85	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,617.50	2,090.85
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	779.95	114.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	69,061.75	2,543.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,061.75	2,543.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON GA 30233-1524

PROVIDER NUMBER 000001856A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP95

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,791,594.40	ADJUSTMENTS	614,433.90
COVERED CHARGES	18,046,516.63	CONTRACTUAL ALLOW	10,073,026.12
NON-COVERED CHARGES	745,077.77	TOTAL MEDICAID LIAB	7,973,490.51
		LESS: COB	41,531.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,931,959.04

TOTAL NUMBER OF ADMISSIONS 2,369

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,392	0	2,412,990.00	482,699.99
NURSERY CARE CHARGES	1,640	0	604,047.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,032	0	3,017,037.00	482,699.99
SPECIAL CARE SERVICES				
C C U	518	0	638,323.00	0.00
I C U	252	0	360,180.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	770	0	998,503.00	0.00
TOTAL ACCOMODATIONS	6,802	0	4,015,540.00	482,699.99

INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,477,423.12	0.00
MED/SURG SUPPLY	1,569,700.05	1,256.00
LABORATORY-GENERAL	2,180,245.00	9,593.00
RADIOLOGY-DIAGNOSTIC	253,271.00	0.00
CT SCAN	381,378.00	810.00
PHYSICAL THERAPY	40,127.00	0.00
EKG/ECG	192,733.00	0.00
IV THERAPY	78,805.00	0.00
OPERATING ROOM	1,563,044.00	0.00
LABOR/DELIVERY ROOM	2,197,065.00	0.00
RESPIRATORY SERVICES	265,761.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	37,800.00	0.00
EMERGENCY ROOM	185,419.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	72,429.00	0.00
RADIOLOGY THERAPEUTIC	1,090.00	0.00
OCCUPATIONAL THERAPY	1,540.00	0.00
SPEECH PATHOLOGY	1,381.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	170,049.00	4,074.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	54,581.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,752.00	130,467.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	148,482.00	0.00
AUDIOLOGY	39,408.00	1,260.00
CARDIOLOGY	433,807.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,512.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	207,177.00	73,746.00
OTHER LAB SERVICES	24,150.00	0.00
RECREATIONAL THERAPY	68.00	0.00
EDUCATION & TRAINING	3,569.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	121,075.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	39,241.30
INJECTABLE DRUGS	301,135.46	332.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,598.00

TOTAL ANCILLARY	14,030,976.63	262,377.78
TOTAL ACCOMODATIONS	4,015,540.00	482,699.99
TOTAL CHARGES	18,046,516.63	745,077.77

ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	26,900.57	ADJUSTMENTS	0.00
COVERED CHARGES	25,135.57	CONTRACTUAL ALLOW	12,301.86
NON-COVERED CHARGES	1,765.00	TOTAL MEDICAID LIAB	12,833.71
		LESS: COB	12,833.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	6,050.00	1,765.00
NURSERY CARE CHARGES	1	0	365.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	6,415.00	1,765.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	6,415.00	1,765.00

ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,994.91	0.00
MED/SURG SUPPLY	780.66	0.00
LABORATORY-GENERAL	2,311.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	10,604.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	490.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	474.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	66.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,720.57	0.00
TOTAL ACCOMODATIONS	6,415.00	1,765.00
TOTAL CHARGES	25,135.57	1,765.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,097,832.96	ADJUSTMENTS	391,795.88
COVERED CHARGES	17,562,978.82	CONTRACTUAL ALLOW	11,922,605.55
NON-COVERED CHARGES	1,534,854.14	TOTAL MEDICAID LIAB	5,640,373.27
		LESS: COB	8,047.98
		LESS: COPAYMENT	11,208.00
		REIMBURSEMENT	5,621,117.29
		ALL OTHER	5,217,652.79
		FEE SCHEDULE-LAB	359,744.91
		INJECTABLE DRUGS	43,719.59

TOTAL NUMBER OF CLAIMS 17,109

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,140,217.20	107,342.77
MED/SURG SUPPLY	989,397.51	35,091.00
LABORATORY-GENERAL	0.00	67,674.00
RADIOLOGY-DIAGNOSTIC	900,577.00	10,086.00
CT SCAN	1,230,587.00	5,920.00
PHYSICAL THERAPY	100,594.00	0.00
EKG/ECG	92,148.00	138.00
IV THERAPY	287,469.00	3,924.00
OPERATING ROOM	1,754,626.67	127,249.83
LABOR/DELIVERY ROOM	54,987.00	75.00
RESPIRATORY SERVICES	59,948.00	56.00
ANESTHESIA	0.00	0.00
GI SERVICES	76,680.00	3,780.00
EMERGENCY ROOM	1,306,142.94	1,410.06
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	326.00
RADIOLOGY THERAPEUTIC	367,063.00	5,161.00
OCCUPATIONAL THERAPY	29,154.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,500.00	150.00
PSYCHIATRIC SERVICES	4,241,412.00	13,968.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	336,355.00	3,026.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	35,222.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	316,033.00	3,105.00
AUDIOLOGY	2,356.00	119.00
CARDIOLOGY	278,154.00	169,415.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	24,024.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	662,800.00	70,239.00
OTHER LAB SERVICES	31,673.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,026.00	75.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,477,157.99	255,322.60
MRI SERVICES	634,029.00	2,260.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	7,578.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	6,506.87
INJECTABLE DRUGS	122,783.51	641,595.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	284.00	249.00

TOTAL ANCILLARY	17,562,978.82	1,534,264.14
TOTAL ACCOMODATIONS	0.00	590.00
TOTAL CHARGES	17,562,978.82	1,534,854.14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,760.38	ADJUSTMENTS	0.00
COVERED CHARGES	57,213.22	CONTRACTUAL ALLOW	27,388.89
NON-COVERED CHARGES	10,547.16	TOTAL MEDICAID LIAB	29,824.33
		LESS: COB	29,788.33
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,175.61-
		FEE SCHEDULE-LAB	1,174.55
		INJECTABLE DRUGS	1.06

TOTAL NUMBER OF CLAIMS 38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,357.54	1,127.12
MED/SURG SUPPLY	3,795.00	102.00
LABORATORY-GENERAL	0.00	55.00
RADIOLOGY-DIAGNOSTIC	1,615.00	1,495.00
CT SCAN	3,997.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	276.00	0.00
IV THERAPY	688.00	0.00
OPERATING ROOM	1,987.90	3,072.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	174.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,080.00	0.00
EMERGENCY ROOM	2,141.50	571.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	545.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	21,534.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	563.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,117.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	465.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,750.00	416.00
OTHER LAB SERVICES	324.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,799.00	923.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4.28	2,757.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	28.00

TOTAL ANCILLARY	57,213.22	10,547.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,213.22	10,547.16

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	630,345.19	ADJUSTMENTS	5,310.77
COVERED CHARGES	613,428.32	CONTRACTUAL ALLOW	516,793.32
NON-COVERED CHARGES	16,916.87	TOTAL MEDICAID LIAB	96,635.00
		LESS: COB	198.46
		LESS: COPAYMENT	1,221.00
		REIMBURSEMENT	95,215.54

TOTAL NUMBER OF CLAIMS 1,934

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,184.53	0.00
MED/SURG SUPPLY	23,587.00	114.00
LABORATORY-GENERAL	121,840.00	5,504.00
RADIOLOGY-DIAGNOSTIC	55,457.00	0.00
CT SCAN	46,561.00	0.00
PHYSICAL THERAPY	269.00	0.00
EKG/ECG	4,830.00	0.00
IV THERAPY	17,780.00	0.00
OPERATING ROOM	1,265.00	0.00
LABOR/DELIVERY ROOM	75.00	0.00
RESPIRATORY SERVICES	1,922.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	270,032.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,364.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	565.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,109.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,065.00	1,995.00
OTHER LAB SERVICES	1,296.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,226.79	9,303.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	613,428.32	16,916.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	613,428.32	16,916.87

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,651.96	ADJUSTMENTS	0.00
COVERED CHARGES	1,913.29	CONTRACTUAL ALLOW	1,910.29
NON-COVERED CHARGES	738.67	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	514.70	0.00
MED/SURG SUPPLY	94.00	0.00
LABORATORY-GENERAL	699.00	329.00
RADIOLOGY-DIAGNOSTIC	138.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	445.33	409.67
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.26	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,913.29	738.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,913.29	738.67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST

CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,718,519.26	ADJUSTMENTS	12,375.18
COVERED CHARGES	1,697,115.10	CONTRACTUAL ALLOW	1,180,982.60
NON-COVERED CHARGES	21,404.16	TOTAL MEDICAID LIAB	516,132.50
		LESS: COB	3,910.00
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	512,012.50

TOTAL NUMBER OF CLAIMS 125

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,754.82	3,544.48
MED/SURG SUPPLY	78,044.56	2,808.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,376.00	308.00
CT SCAN	13,577.00	383.00
PHYSICAL THERAPY	673.00	0.00
EKG/ECG	276.00	0.00
IV THERAPY	1,363.00	0.00
OPERATING ROOM	134,090.00	8,855.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	579.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,689.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	253,279.00	852.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	1,095,034.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	668.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,888.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,109.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,280.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,423.00	1,214.00
MRI SERVICES	7,239.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,772.72	3,439.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,697,115.10	21,404.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,697,115.10	21,404.16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,415,145.82	ADJUSTMENTS	626,078.93
COVERED CHARGES	18,240,063.59	CONTRACTUAL ALLOW	10,889,723.60
NON-COVERED CHARGES	1,175,082.23	TOTAL MEDICAID LIAB	7,350,339.99
		LESS: COB	33,317.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,317,022.67

TOTAL NUMBER OF ADMISSIONS 2,220

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,900	428	2,145,000.00	948,917.00
NURSERY CARE CHARGES	1,470	0	563,220.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,370	428	2,708,220.00	948,917.00
SPECIAL CARE SERVICES				
C C U	406	0	476,421.00	0.00
I C U	252	0	393,120.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	658	0	869,541.00	0.00
TOTAL ACCOMODATIONS	6,028	428	3,577,761.00	948,917.00

INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,815,390.16	0.00
MED/SURG SUPPLY	1,628,250.25	2,683.00
LABORATORY-GENERAL	2,380,603.00	540.00
RADIOLOGY-DIAGNOSTIC	265,155.00	0.00
CT SCAN	431,785.00	0.00
PHYSICAL THERAPY	49,463.00	0.00
EKG/ECG	168,342.00	0.00
IV THERAPY	18,941.00	0.00
OPERATING ROOM	1,420,278.00	0.00
LABOR/DELIVERY ROOM	2,202,830.00	0.00
RESPIRATORY SERVICES	424,006.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	19,086.00	0.00
EMERGENCY ROOM	204,163.00	0.00
RECOVERY ROOM	3,157.00	0.00
LABORATORY PATHOLOGIC	69,351.00	0.00
RADIOLOGY THERAPEUTIC	6,591.00	336.00
OCCUPATIONAL THERAPY	567.00	0.00
SPEECH PATHOLOGY	3,494.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	262.00
PSYCHIATRIC SERVICES	188,294.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	47,395.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,462.00	95,208.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	105,255.00	0.00
AUDIOLOGY	3,588.00	36,984.00
CARDIOLOGY	361,050.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,558.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	198,135.00	57,891.00
OTHER LAB SERVICES	31,245.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,778.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	148,653.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	29,800.23
INJECTABLE DRUGS	448,437.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,461.00

TOTAL ANCILLARY	14,662,302.59	226,165.23
TOTAL ACCOMODATIONS	3,577,761.00	948,917.00
TOTAL CHARGES	18,240,063.59	1,175,082.23

ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,981.29	ADJUSTMENTS	0.00
COVERED CHARGES	13,712.29	CONTRACTUAL ALLOW	5,237.06
NON-COVERED CHARGES	269.00	TOTAL MEDICAID LIAB	8,475.23
		LESS: COB	8,475.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	1,100.00	200.00
NURSERY CARE CHARGES	4	0	1,520.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	2,620.00	200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,620.00	200.00

ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,995.79	0.00
MED/SURG SUPPLY	905.50	0.00
LABORATORY-GENERAL	1,190.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,748.00	0.00
LABOR/DELIVERY ROOM	4,075.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	178.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	69.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,092.29	69.00
TOTAL ACCOMODATIONS	2,620.00	200.00
TOTAL CHARGES	13,712.29	269.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	21,558,281.20	ADJUSTMENTS	214,864.33
COVERED CHARGES	18,708,985.79	CONTRACTUAL ALLOW	14,381,815.17
NON-COVERED CHARGES	2,849,295.41	TOTAL MEDICAID LIAB	4,327,170.62
		LESS: COB	5,788.38
		LESS: COPAYMENT	15,372.00
		REIMBURSEMENT	4,306,010.24
		ALL OTHER	3,918,863.05
		FEE SCHEDULE-LAB	367,939.93
		INJECTABLE DRUGS	19,207.26

TOTAL NUMBER OF CLAIMS 16,720

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,174,935.18	10,814.37
MED/SURG SUPPLY	990,701.36	22,608.00
LABORATORY-GENERAL	2,224.00	60,142.00
RADIOLOGY-DIAGNOSTIC	852,003.00	7,156.00
CT SCAN	1,071,576.00	78,638.00
PHYSICAL THERAPY	135,040.00	213.00
EKG/ECG	111,975.00	0.00
IV THERAPY	92,873.00	58,880.00
OPERATING ROOM	1,759,174.00	59,921.00
LABOR/DELIVERY ROOM	42,865.00	0.00
RESPIRATORY SERVICES	60,259.00	200.00
ANESTHESIA	0.00	0.00
GI SERVICES	44,398.00	1,124.00
EMERGENCY ROOM	1,284,164.32	54,817.68
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	2,010.00
RADIOLOGY THERAPEUTIC	569,717.00	77,742.00
OCCUPATIONAL THERAPY	23,882.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,595.00	4,843.00
PSYCHIATRIC SERVICES	5,325,243.00	1,404.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	315,274.00	23,073.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,608.00	966.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	293,691.00	5,077.00
AUDIOLOGY	0.00	69.00
CARDIOLOGY	464,852.00	30,636.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,828.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	564,886.00	93,113.00
OTHER LAB SERVICES	38,274.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,236.00	1,825.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,646,299.29	194,641.00
MRI SERVICES	716,139.00	10,536.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	272.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	515.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,641.81
INJECTABLE DRUGS	78,758.64	2,039,004.55
HOME HEALTH SERVICES	0.00	108.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,060.00

TOTAL ANCILLARY	18,708,985.79	2,848,535.41
TOTAL ACCOMODATIONS	0.00	760.00
TOTAL CHARGES	18,708,985.79	2,849,295.41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	222,844.93	ADJUSTMENTS	0.00
COVERED CHARGES	52,780.68	CONTRACTUAL ALLOW	42,109.94
NON-COVERED CHARGES	170,064.25	TOTAL MEDICAID LIAB	10,670.74
		LESS: COB	10,610.74
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		ALL OTHER	379.10-
		FEE SCHEDULE-LAB	377.25
		INJECTABLE DRUGS	1.85

TOTAL NUMBER OF CLAIMS 66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,481.48	0.00
MED/SURG SUPPLY	2,856.70	0.00
LABORATORY-GENERAL	0.00	185.00
RADIOLOGY-DIAGNOSTIC	621.00	0.00
CT SCAN	7,904.00	19,534.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	383.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	78.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	899.00	92.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,342.00	6,193.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,421.00
PSYCHIATRIC SERVICES	13,915.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	25,872.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,728.00	93.00
OTHER LAB SERVICES	802.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	240.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,146.00	343.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7.50	115,708.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	52,780.68	170,064.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,780.68	170,064.25

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	701,082.89	ADJUSTMENTS	2,167.00
COVERED CHARGES	667,964.72	CONTRACTUAL ALLOW	564,454.72
NON-COVERED CHARGES	33,118.17	TOTAL MEDICAID LIAB	103,510.00
		LESS: COB	47.62
		LESS: COPAYMENT	2,424.00
		REIMBURSEMENT	101,038.38

TOTAL NUMBER OF CLAIMS 2,073

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,540.42	0.00
MED/SURG SUPPLY	24,700.00	76.00
LABORATORY-GENERAL	125,352.00	5,344.00
RADIOLOGY-DIAGNOSTIC	63,818.00	144.00
CT SCAN	38,913.00	1,305.00
PHYSICAL THERAPY	275.00	0.00
EKG/ECG	5,772.00	0.00
IV THERAPY	7,936.00	428.00
OPERATING ROOM	3,945.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,780.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	562.00	0.00
EMERGENCY ROOM	305,034.00	5,762.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	804.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	40.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,792.00	872.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,211.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,306.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,274.00	0.00
OTHER LAB SERVICES	2,022.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,047.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,841.30	19,187.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	667,964.72	33,118.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	667,964.72	33,118.17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,744.90	ADJUSTMENTS	0.00
COVERED CHARGES	1,427.90	CONTRACTUAL ALLOW	1,427.90
NON-COVERED CHARGES	317.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512.90	0.00
MED/SURG SUPPLY	153.00	0.00
LABORATORY-GENERAL	251.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	511.00	296.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	21.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,427.90	317.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,427.90	317.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST

CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	877,039.65	ADJUSTMENTS	3,528.48
COVERED CHARGES	846,743.00	CONTRACTUAL ALLOW	695,680.90
NON-COVERED CHARGES	30,296.65	TOTAL MEDICAID LIAB	151,062.10
		LESS: COB	0.00
		LESS: COPAYMENT	972.00
		REIMBURSEMENT	150,090.10

TOTAL NUMBER OF CLAIMS 43

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0131GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,472.50	86.08
MED/SURG SUPPLY	74,825.27	7,555.00
LABORATORY-GENERAL	0.00	69.00
RADIOLOGY-DIAGNOSTIC	3,604.00	321.00
CT SCAN	5,386.00	0.00
PHYSICAL THERAPY	1,110.00	0.00
EKG/ECG	468.00	0.00
IV THERAPY	758.00	339.00
OPERATING ROOM	148,468.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	634.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,196.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	409,268.00	10,198.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	131.00	204.00
PSYCHIATRIC SERVICES	67,155.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	586.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,117.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,153.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,655.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,539.76	7,836.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,216.47	3,687.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	846,743.00	30,296.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	846,743.00	30,296.65

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER
705 DIXIE ST
CARROLLTON GA 30117-3818

PROVIDER NUMBER 000001867A
NUMBER OF BEDS 167
TITLE XVIII NO: HPH0131GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,545,177.83	ADJUSTMENTS	72,568.50
COVERED CHARGES	5,496,928.10	CONTRACTUAL ALLOW	3,195,753.48
NON-COVERED CHARGES	48,249.73	TOTAL MEDICAID LIAB	2,301,174.62
		LESS: COB	9,500.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,291,674.51

TOTAL NUMBER OF ADMISSIONS 709

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	946	0	520,300.00	38,252.00
NURSERY CARE CHARGES	600	0	219,060.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,546	0	739,360.00	38,252.00
SPECIAL CARE SERVICES				
C C U	187	0	230,384.00	0.00
I C U	150	0	213,885.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	337	0	444,269.00	0.00
TOTAL ACCOMODATIONS	1,883	0	1,183,629.00	38,252.00

INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,141,649.74	0.00
MED/SURG SUPPLY	496,966.70	410.00
LABORATORY-GENERAL	698,846.00	855.00
RADIOLOGY-DIAGNOSTIC	77,444.00	0.00
CT SCAN	132,157.00	0.00
PHYSICAL THERAPY	7,230.00	0.00
EKG/ECG	34,638.00	0.00
IV THERAPY	29,515.00	0.00
OPERATING ROOM	455,468.00	0.00
LABOR/DELIVERY ROOM	582,144.00	0.00
RESPIRATORY SERVICES	204,232.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	7,020.00	0.00
EMERGENCY ROOM	52,712.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	22,945.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	323.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,150.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,450.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	32,234.00	0.00
AUDIOLOGY	14,925.00	333.00
CARDIOLOGY	91,086.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,730.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	49,614.00	5,965.00
OTHER LAB SERVICES	8,398.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	140.00	35.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	38,914.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,399.73
INJECTABLE DRUGS	91,367.66	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,313,299.10	9,997.73
TOTAL ACCOMODATIONS	1,183,629.00	38,252.00
TOTAL CHARGES	5,496,928.10	48,249.73

ZERO PAID INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,794.19	ADJUSTMENTS	0.00
COVERED CHARGES	9,714.19	CONTRACTUAL ALLOW	1,097.37
NON-COVERED CHARGES	80.00	TOTAL MEDICAID LIAB	8,616.82
		LESS: COB	8,616.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	1,100.00	80.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,100.00	80.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,100.00	80.00

ZERO PAID INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,303.19	0.00
MED/SURG SUPPLY	1,326.00	0.00
LABORATORY-GENERAL	569.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,795.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	82.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	248.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	291.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,614.19	0.00
TOTAL ACCOMODATIONS	1,100.00	80.00
TOTAL CHARGES	9,714.19	80.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,039,842.75	ADJUSTMENTS	266,587.94
COVERED CHARGES	7,686,372.83	CONTRACTUAL ALLOW	4,313,730.39
NON-COVERED CHARGES	353,469.92	TOTAL MEDICAID LIAB	3,372,642.44
		LESS: COB	5,072.07
		LESS: COPAYMENT	5,019.00
		REIMBURSEMENT	3,362,551.37
		ALL OTHER	3,230,525.77
		FEE SCHEDULE-LAB	118,584.92
		INJECTABLE DRUGS	13,440.68

TOTAL NUMBER OF CLAIMS 7,050

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	516,827.63	40,110.73
MED/SURG SUPPLY	377,574.59	21,830.50
LABORATORY-GENERAL	266.00	5,000.00
RADIOLOGY-DIAGNOSTIC	382,806.00	9,188.00
CT SCAN	717,337.00	0.00
PHYSICAL THERAPY	32,317.00	0.00
EKG/ECG	53,329.00	0.00
IV THERAPY	152,077.00	225.00
OPERATING ROOM	622,253.00	45,540.00
LABOR/DELIVERY ROOM	10,983.00	455.00
RESPIRATORY SERVICES	47,987.00	713.00
ANESTHESIA	0.00	0.00
GI SERVICES	24,840.00	1,080.00
EMERGENCY ROOM	707,801.50	94.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	815.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	187.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,124.00	0.00
PSYCHIATRIC SERVICES	1,871,358.00	351.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	147,260.00	9,403.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	40,008.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	160,787.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	141,636.00	7,340.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,006.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	291,704.00	11,956.00
OTHER LAB SERVICES	25,574.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	325.00	3,213.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	896,640.91	103,399.51
MRI SERVICES	429,484.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	294.42
INJECTABLE DRUGS	27,880.20	91,871.26
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,686,372.83	352,879.92
TOTAL ACCOMODATIONS	0.00	590.00
TOTAL CHARGES	7,686,372.83	353,469.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	40,207.40	ADJUSTMENTS	0.00
COVERED CHARGES	16,286.01	CONTRACTUAL ALLOW	9,868.31
NON-COVERED CHARGES	23,921.39	TOTAL MEDICAID LIAB	6,417.70
		LESS: COB	6,405.70
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	238.80-
		FEE SCHEDULE-LAB	238.80
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,094.01	0.00
MED/SURG SUPPLY	217.00	0.00
LABORATORY-GENERAL	0.00	164.00
RADIOLOGY-DIAGNOSTIC	681.00	0.00
CT SCAN	1,439.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	138.00	0.00
IV THERAPY	0.00	238.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	87.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	953.00	106.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	9,894.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	16,592.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	385.00	410.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,398.00	1,592.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,819.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,286.01	23,921.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,286.01	23,921.39

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	469,769.66	ADJUSTMENTS	3,621.52
COVERED CHARGES	457,100.80	CONTRACTUAL ALLOW	376,650.80
NON-COVERED CHARGES	12,668.86	TOTAL MEDICAID LIAB	80,450.00
		LESS: COB	143.43
		LESS: COPAYMENT	1,137.00
		REIMBURSEMENT	79,169.57

TOTAL NUMBER OF CLAIMS 1,609

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,189.30	1,114.00
MED/SURG SUPPLY	16,414.00	0.00
LABORATORY-GENERAL	74,039.00	4,467.00
RADIOLOGY-DIAGNOSTIC	43,221.00	0.00
CT SCAN	35,924.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,002.00	0.00
IV THERAPY	14,842.00	225.00
OPERATING ROOM	3,795.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,524.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	206,598.00	78.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	189.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,570.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,328.00	0.00
OTHER LAB SERVICES	2,125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,260.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,080.50	6,784.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	457,100.80	12,668.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	457,100.80	12,668.86

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	693.00	ADJUSTMENTS	0.00
COVERED CHARGES	640.00	CONTRACTUAL ALLOW	493.50
NON-COVERED CHARGES	53.00	TOTAL MEDICAID LIAB	146.50
		LESS: COB	143.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	319.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	258.00	53.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	640.00	53.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	640.00	53.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES	THROUGH
601 DALLAS HWY	000002032A	53	SERVICE DATES 07/01/2004	THROUGH 06/30/2005
	TITLE XVIII NO: HOSP206			
VILLA RICA GA 30180-1202				

CHARGES		PAYMENTS	
TOTAL CHARGES	1,498,512.94	ADJUSTMENTS	25,310.82
COVERED CHARGES	1,481,827.28	CONTRACTUAL ALLOW	894,139.45
NON-COVERED CHARGES	16,685.66	TOTAL MEDICAID LIAB	587,687.83
		LESS: COB	120.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	587,468.83

TOTAL NUMBER OF CLAIMS 139

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,868.44	3,850.00
MED/SURG SUPPLY	36,781.91	0.00
LABORATORY-GENERAL	0.00	11.00
RADIOLOGY-DIAGNOSTIC	3,155.00	362.00
CT SCAN	20,122.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,070.00	0.00
IV THERAPY	17,850.00	0.00
OPERATING ROOM	74,635.00	5,060.00
LABOR/DELIVERY ROOM	225.00	0.00
RESPIRATORY SERVICES	827.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,013.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	1,218,708.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	906.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	904.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,601.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,296.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,482.00	61.00
OTHER LAB SERVICES	358.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,453.00	2,909.00
MRI SERVICES	2,719.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	883.26
INJECTABLE DRUGS	2,852.93	3,549.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,481,827.28	16,685.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,481,827.28	16,685.66

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,391,809.85	ADJUSTMENTS	525,895.83
COVERED CHARGES	6,268,848.73	CONTRACTUAL ALLOW	3,624,572.43
NON-COVERED CHARGES	122,961.12	TOTAL MEDICAID LIAB	2,644,276.30
		LESS: COB	13,964.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,630,311.31

TOTAL NUMBER OF ADMISSIONS 745

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	980	0	539,000.00	97,300.00
NURSERY CARE CHARGES	558	0	212,110.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	1,538	4	751,110.00	97,300.00
SPECIAL CARE SERVICES				
C C U	230	0	255,289.00	0.00
I C U	174	0	271,440.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	404	0	526,729.00	0.00
TOTAL ACCOMODATIONS	1,942	4	1,277,839.00	97,300.00

INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,365,816.53	0.00
MED/SURG SUPPLY	472,462.28	213.00
LABORATORY-GENERAL	866,689.00	0.00
RADIOLOGY-DIAGNOSTIC	103,303.00	0.00
CT SCAN	152,546.00	0.00
PHYSICAL THERAPY	4,824.00	0.00
EKG/ECG	34,632.00	0.00
IV THERAPY	8,150.00	0.00
OPERATING ROOM	412,693.00	0.00
LABOR/DELIVERY ROOM	655,603.00	0.00
RESPIRATORY SERVICES	290,901.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,678.00	0.00
EMERGENCY ROOM	73,760.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	18,973.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	585.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,897.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,266.00	332.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,059.00	0.00
AUDIOLOGY	828.00	16,629.00
CARDIOLOGY	100,708.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,184.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,454.00	637.00
OTHER LAB SERVICES	11,929.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	367.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	49,850.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	7,850.12
INJECTABLE DRUGS	195,851.92	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,991,009.73	25,661.12
TOTAL ACCOMODATIONS	1,277,839.00	97,300.00
TOTAL CHARGES	6,268,848.73	122,961.12

ZERO PAID INPATIENT PAID CLAIMS

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,680,315.04	ADJUSTMENTS	54,688.44
COVERED CHARGES	9,105,202.72	CONTRACTUAL ALLOW	6,774,151.58
NON-COVERED CHARGES	575,112.32	TOTAL MEDICAID LIAB	2,331,051.14
		LESS: COB	823.23
		LESS: COPAYMENT	6,318.00
		REIMBURSEMENT	2,323,909.91
		ALL OTHER	2,167,114.04
		FEE SCHEDULE-LAB	145,059.23
		INJECTABLE DRUGS	11,736.64

TOTAL NUMBER OF CLAIMS 8,197

OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	526,681.29	7,511.27
MED/SURG SUPPLY	409,815.87	3,351.00
LABORATORY-GENERAL	834.00	6,735.00
RADIOLOGY-DIAGNOSTIC	455,700.00	1,671.00
CT SCAN	730,109.00	41,379.00
PHYSICAL THERAPY	50,408.00	124.00
EKG/ECG	72,027.00	0.00
IV THERAPY	68,748.00	31,877.00
OPERATING ROOM	556,698.00	47,340.00
LABOR/DELIVERY ROOM	15,406.00	0.00
RESPIRATORY SERVICES	61,273.00	261.00
ANESTHESIA	0.00	0.00
GI SERVICES	9,554.00	0.00
EMERGENCY ROOM	897,159.00	38,607.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	920.00	0.00
PSYCHIATRIC SERVICES	2,928,595.00	15,145.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	163,755.00	6,459.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,480.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	141,272.00	2,571.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	137,645.00	12,727.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,644.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	264,618.00	45,538.00
OTHER LAB SERVICES	19,730.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	583.00	197.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,141,916.47	124,453.00
MRI SERVICES	396,823.00	7,524.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,808.09	181,642.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,105,202.72	575,112.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,105,202.72	575,112.32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,089.12	ADJUSTMENTS	0.00
COVERED CHARGES	4,186.78	CONTRACTUAL ALLOW	4,171.78
NON-COVERED CHARGES	15,902.34	TOTAL MEDICAID LIAB	15.00
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	60.46-
		FEE SCHEDULE-LAB	3.05
		INJECTABLE DRUGS	57.41

TOTAL NUMBER OF CLAIMS 15

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	25.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	378.00	0.00
CT SCAN	2,992.00	7,904.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	222.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	184.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	31.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	80.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	176.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	209.78	7,887.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,186.78	15,902.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,186.78	15,902.34

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	709,898.73	ADJUSTMENTS	1,688.00
COVERED CHARGES	671,252.28	CONTRACTUAL ALLOW	548,450.28
NON-COVERED CHARGES	38,646.45	TOTAL MEDICAID LIAB	122,802.00
		LESS: COB	104.21
		LESS: COPAYMENT	2,601.00
		REIMBURSEMENT	120,096.79

TOTAL NUMBER OF CLAIMS 2,458

OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,876.10	0.00
MED/SURG SUPPLY	18,101.00	0.00
LABORATORY-GENERAL	130,897.00	7,186.00
RADIOLOGY-DIAGNOSTIC	57,672.00	0.00
CT SCAN	34,842.00	1,069.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,708.00	0.00
IV THERAPY	6,696.00	248.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	78.00	0.00
RESPIRATORY SERVICES	2,815.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	328,654.67	8,183.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,517.00	2,359.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,291.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,153.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,229.00	0.00
OTHER LAB SERVICES	674.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,048.51	19,400.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	201.33

TOTAL ANCILLARY	671,252.28	38,646.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	671,252.28	38,646.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,309.86	ADJUSTMENTS	0.00
COVERED CHARGES	4,819.86	CONTRACTUAL ALLOW	4,807.86
NON-COVERED CHARGES	490.00	TOTAL MEDICAID LIAB	12.00
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	807.41	0.00
MED/SURG SUPPLY	167.00	0.00
LABORATORY-GENERAL	1,389.00	249.00
RADIOLOGY-DIAGNOSTIC	567.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	156.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	235.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,482.00	241.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,819.86	490.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,819.86	490.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP
601 DALLAS HWY
VILLA RICA GA 30180-1202

PROVIDER NUMBER 000002032A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP206

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	317,051.10	ADJUSTMENTS	3,619.14
COVERED CHARGES	309,924.65	CONTRACTUAL ALLOW	233,922.71
NON-COVERED CHARGES	7,126.45	TOTAL MEDICAID LIAB	76,001.94
		LESS: COB	0.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	75,860.94

TOTAL NUMBER OF CLAIMS 21

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP PROVIDER NUMBER NUMBER OF BEDS PAYMENT DATES THROUGH
601 DALLAS HWY 000002032A 53 SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP206
VILLA RICA GA 30180-1202

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,913.29	0.00
MED/SURG SUPPLY	34,448.88	38.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,015.00	0.00
CT SCAN	11,968.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	780.00	0.00
IV THERAPY	504.00	0.00
OPERATING ROOM	56,545.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	74.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,021.00	86.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	153,670.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,587.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,026.00	3,564.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,566.00	921.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	806.48	2,517.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	309,924.65	7,126.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	309,924.65	7,126.45

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MED CTR/VILLA RICA HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES	THROUGH
601 DALLAS HWY	000002032A	53	SERVICE DATES 07/01/2005	THROUGH 06/30/2006
	TITLE XVIII NO: HOSP206			
VILLA RICA GA 30180-1202				

****** NO DATA ******

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	401,315.30	ADJUSTMENTS	0.00
COVERED CHARGES	396,685.80	CONTRACTUAL ALLOW	94,118.29
NON-COVERED CHARGES	4,629.50	TOTAL MEDICAID LIAB	302,567.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	302,567.51

TOTAL NUMBER OF ADMISSIONS 74

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	197	0	54,175.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	197	0	54,175.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	197	0	54,175.00	0.00

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,379.15	0.00
MED/SURG SUPPLY	42,021.02	0.00
LABORATORY-GENERAL	71,637.42	0.00
RADIOLOGY-DIAGNOSTIC	15,004.75	0.00
CT SCAN	41,620.10	0.00
PHYSICAL THERAPY	1,542.65	0.00
EKG/ECG	6,114.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,125.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,238.12	0.00
ANESTHESIA	748.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,096.90	0.00
RECOVERY ROOM	1,155.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,698.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,860.00	1,082.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,891.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,868.89	0.00
OTHER LAB SERVICES	510.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,547.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	342,510.80	4,629.50
TOTAL ACCOMODATIONS	54,175.00	0.00
TOTAL CHARGES	396,685.80	4,629.50

ZERO PAID INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,947,425.57	ADJUSTMENTS	4,385.70
COVERED CHARGES	1,781,016.10	CONTRACTUAL ALLOW	944,418.11
NON-COVERED CHARGES	166,409.47	TOTAL MEDICAID LIAB	836,597.99
		LESS: COB	1,931.20
		LESS: COPAYMENT	3,555.00
		REIMBURSEMENT	831,111.79
		ALL OTHER	777,205.36
		FEE SCHEDULE-LAB	53,906.43
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,211

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,130.92	1,561.50
MED/SURG SUPPLY	95,776.76	22.87
LABORATORY-GENERAL	0.00	2,927.31
RADIOLOGY-DIAGNOSTIC	176,679.48	900.00
CT SCAN	204,953.28	7,036.88
PHYSICAL THERAPY	18,596.78	7,654.50
EKG/ECG	27,932.96	351.10
IV THERAPY	0.00	0.00
OPERATING ROOM	22,822.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,619.15	566.62
ANESTHESIA	2,145.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	516,654.49	14,622.95
RECOVERY ROOM	4,990.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	36,012.10	2,358.70
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,787.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,555.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	62,581.05	6,874.33
OTHER LAB SERVICES	14,483.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	435,083.68	103,924.93
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	13,931.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	888.78

TOTAL ANCILLARY	1,781,016.10	166,409.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,781,016.10	166,409.47

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	15,089.16	ADJUSTMENTS	0.00
COVERED CHARGES	14,434.82	CONTRACTUAL ALLOW	2,085.83
NON-COVERED CHARGES	654.34	TOTAL MEDICAID LIAB	12,348.99
		LESS: COB	12,330.99
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	537.64-
		FEE SCHEDULE-LAB	537.64
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	700.00	0.00
MED/SURG SUPPLY	737.61	4.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,050.95	0.00
CT SCAN	2,446.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	124.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46.35	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,570.25	65.95
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	123.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	124.75	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,510.81	542.89
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	41.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,434.82	654.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,434.82	654.34

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	149,633.09	ADJUSTMENTS	50.00
COVERED CHARGES	146,361.69	CONTRACTUAL ALLOW	124,461.69
NON-COVERED CHARGES	3,271.40	TOTAL MEDICAID LIAB	21,900.00
		LESS: COB	9.57
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	21,431.43

TOTAL NUMBER OF CLAIMS 438

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,327.52	80.00
MED/SURG SUPPLY	3,547.80	0.00
LABORATORY-GENERAL	19,447.86	2,584.75
RADIOLOGY-DIAGNOSTIC	6,792.10	0.00
CT SCAN	7,621.96	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	917.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	366.64	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	84,805.35	606.65
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,128.86	0.00
OTHER LAB SERVICES	406.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	146,361.69	3,271.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	146,361.69	3,271.40

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	718.50	ADJUSTMENTS	0.00
COVERED CHARGES	718.50	CONTRACTUAL ALLOW	192.09
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	526.41
		LESS: COB	526.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	483.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	718.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	718.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST

REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	77,107.35	ADJUSTMENTS	0.00
COVERED CHARGES	65,075.98	CONTRACTUAL ALLOW	34,970.22
NON-COVERED CHARGES	12,031.37	TOTAL MEDICAID LIAB	30,105.76
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	30,087.76

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,050.00	0.00
MED/SURG SUPPLY	15,321.63	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,191.35	0.00
CT SCAN	7,107.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	588.90	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,689.45	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	940.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,913.25	276.90
RECOVERY ROOM	5,022.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,121.80	1,648.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,128.90	1,093.97
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	9,012.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	65,075.98	12,031.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,075.98	12,031.37

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	687,122.39	ADJUSTMENTS	0.00
COVERED CHARGES	681,657.34	CONTRACTUAL ALLOW	327,903.21
NON-COVERED CHARGES	5,465.05	TOTAL MEDICAID LIAB	353,754.13
		LESS: COB	1,050.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	352,704.13

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	285	0	78,375.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	285	0	78,375.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	285	0	78,375.00	0.00

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,342.00	0.00
MED/SURG SUPPLY	86,403.24	440.55
LABORATORY-GENERAL	140,357.00	0.00
RADIOLOGY-DIAGNOSTIC	22,242.50	0.00
CT SCAN	45,004.00	0.00
PHYSICAL THERAPY	5,256.50	0.00
EKG/ECG	8,613.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,198.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	44,126.50	0.00
ANESTHESIA	643.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	35,577.00	0.00
RECOVERY ROOM	866.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,008.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,079.00	1,785.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,307.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,967.00	0.00
OTHER LAB SERVICES	853.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,437.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,239.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	603,282.34	5,465.05
TOTAL ACCOMODATIONS	78,375.00	0.00
TOTAL CHARGES	681,657.34	5,465.05

ZERO PAID INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,026,839.03	ADJUSTMENTS	94,581.45
COVERED CHARGES	1,853,499.86	CONTRACTUAL ALLOW	825,778.05
NON-COVERED CHARGES	173,339.17	TOTAL MEDICAID LIAB	1,027,721.81
		LESS: COB	1,651.56
		LESS: COPAYMENT	1,761.00
		REIMBURSEMENT	1,024,309.25
		ALL OTHER	972,363.59
		FEE SCHEDULE-LAB	51,845.90
		INJECTABLE DRUGS	99.76

TOTAL NUMBER OF CLAIMS 2,860

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,244.42	23,487.50
MED/SURG SUPPLY	101,745.67	0.00
LABORATORY-GENERAL	0.00	4,414.50
RADIOLOGY-DIAGNOSTIC	164,237.50	367.00
CT SCAN	177,635.50	11,703.00
PHYSICAL THERAPY	15,596.00	9,397.50
EKG/ECG	32,886.50	0.00
IV THERAPY	76.00	0.00
OPERATING ROOM	15,305.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,643.00	0.00
ANESTHESIA	1,859.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	584,914.00	5,520.50
RECOVERY ROOM	2,946.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	81.00	81.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	30,311.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,220.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,286.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	65,319.64	2,886.67
OTHER LAB SERVICES	21,329.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	455,962.65	104,534.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,656.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	121.48	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	71.50

TOTAL ANCILLARY	1,853,499.86	173,339.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,853,499.86	173,339.17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	26,858.49	ADJUSTMENTS	0.00
COVERED CHARGES	23,812.99	CONTRACTUAL ALLOW	2,404.44
NON-COVERED CHARGES	3,045.50	TOTAL MEDICAID LIAB	21,408.55
		LESS: COB	21,393.55
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	769.18-
		FEE SCHEDULE-LAB	769.18
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,537.00	37.00
MED/SURG SUPPLY	1,156.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,078.00	202.00
CT SCAN	3,850.00	1,284.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	391.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,692.50	304.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	535.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	387.49	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,185.00	1,102.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	116.50

TOTAL ANCILLARY	23,812.99	3,045.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,812.99	3,045.50

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	226,914.45	ADJUSTMENTS	3,071.00
COVERED CHARGES	220,294.95	CONTRACTUAL ALLOW	192,401.95
NON-COVERED CHARGES	6,619.50	TOTAL MEDICAID LIAB	27,893.00
		LESS: COB	26.73
		LESS: COPAYMENT	636.00
		REIMBURSEMENT	27,230.27

TOTAL NUMBER OF CLAIMS 558

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,218.00	86.50
MED/SURG SUPPLY	4,462.94	0.00
LABORATORY-GENERAL	32,786.50	3,786.00
RADIOLOGY-DIAGNOSTIC	10,443.50	0.00
CT SCAN	16,195.00	0.00
PHYSICAL THERAPY	0.00	419.00
EKG/ECG	1,827.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	373.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	123,732.00	2,328.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	535.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,026.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,680.15	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.36	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	220,294.95	6,619.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	220,294.95	6,619.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,203.22	ADJUSTMENTS	0.00
COVERED CHARGES	6,844.72	CONTRACTUAL ALLOW	2,423.77
NON-COVERED CHARGES	358.50	TOTAL MEDICAID LIAB	4,420.95
		LESS: COB	4,411.95
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	506.50	0.00
MED/SURG SUPPLY	209.00	0.00
LABORATORY-GENERAL	2,074.72	84.00
RADIOLOGY-DIAGNOSTIC	549.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,784.50	274.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	577.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	144.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,844.72	358.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,844.72	358.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST

REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	288,883.78	ADJUSTMENTS	14,728.36
COVERED CHARGES	230,593.78	CONTRACTUAL ALLOW	126,674.96
NON-COVERED CHARGES	58,290.00	TOTAL MEDICAID LIAB	103,918.82
		LESS: COB	750.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	103,108.82

TOTAL NUMBER OF CLAIMS 29

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,884.50	6,363.00
MED/SURG SUPPLY	50,987.78	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,978.50	0.00
CT SCAN	14,549.50	462.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,088.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	70,178.50	6,065.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,472.50	0.00
ANESTHESIA	9,295.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,439.50	228.00
RECOVERY ROOM	15,423.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	535.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	732.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,048.50	582.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,981.00	2,553.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	42,037.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	230,593.78	58,290.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	230,593.78	58,290.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,021,758.74	ADJUSTMENTS	15,220.42
COVERED CHARGES	1,009,829.49	CONTRACTUAL ALLOW	416,532.64
NON-COVERED CHARGES	11,929.25	TOTAL MEDICAID LIAB	593,296.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	593,296.85

TOTAL NUMBER OF ADMISSIONS 126

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	436	0	119,355.00	95.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	436	0	119,355.00	95.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	436	0	119,355.00	95.00

INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,863.00	0.00
MED/SURG SUPPLY	129,400.12	728.25
LABORATORY-GENERAL	205,145.30	0.00
RADIOLOGY-DIAGNOSTIC	28,815.25	0.00
CT SCAN	106,312.25	0.00
PHYSICAL THERAPY	4,058.75	0.00
EKG/ECG	14,723.50	0.00
IV THERAPY	1,902.00	0.00
OPERATING ROOM	12,997.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	42,700.75	0.00
ANESTHESIA	1,490.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,787.50	0.00
RECOVERY ROOM	2,496.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,747.75	0.00
BLOOD	160.50	0.00
BLOOD STORAGE & PRO.	1,732.50	1,785.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,797.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,732.75	0.00
OTHER LAB SERVICES	4,794.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	348.63	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	9,321.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	53,468.94	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	890,474.49	11,834.25
TOTAL ACCOMODATIONS	119,355.00	95.00
TOTAL CHARGES	1,009,829.49	11,929.25

ZERO PAID INPATIENT PAID CLAIMS

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,056,383.57	ADJUSTMENTS	305,292.94
COVERED CHARGES	1,823,502.74	CONTRACTUAL ALLOW	923,320.12
NON-COVERED CHARGES	232,880.83	TOTAL MEDICAID LIAB	900,182.62
		LESS: COB	2,112.91
		LESS: COPAYMENT	1,767.00
		REIMBURSEMENT	896,302.71
		ALL OTHER	838,094.94
		FEE SCHEDULE-LAB	47,661.73
		INJECTABLE DRUGS	10,546.04

TOTAL NUMBER OF CLAIMS 2,490

OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,389.40	10,277.00
MED/SURG SUPPLY	91,094.96	155.50
LABORATORY-GENERAL	0.00	7,343.75
RADIOLOGY-DIAGNOSTIC	157,079.25	963.50
CT SCAN	168,995.25	53,135.00
PHYSICAL THERAPY	22,592.75	6,786.00
EKG/ECG	32,193.00	417.75
IV THERAPY	8,498.00	0.00
OPERATING ROOM	26,623.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,004.50	698.50
ANESTHESIA	4,607.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	546,693.46	31,007.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	81.00	59.50
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,735.50	1,391.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,732.50	1,487.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,165.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	60,932.54	144.00
OTHER LAB SERVICES	19,313.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	443,758.92	100,742.58
MRI SERVICES	1,948.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	17,682.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,063.96	39.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,823,502.74	232,330.83
TOTAL ACCOMODATIONS	0.00	550.00
TOTAL CHARGES	1,823,502.74	232,880.83

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,917.50	ADJUSTMENTS	0.00
COVERED CHARGES	12,847.50	CONTRACTUAL ALLOW	2,738.30
NON-COVERED CHARGES	1,070.00	TOTAL MEDICAID LIAB	10,109.20
		LESS: COB	10,106.20
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	400.49-
		FEE SCHEDULE-LAB	345.69
		INJECTABLE DRUGS	54.80

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	442.25	37.00
MED/SURG SUPPLY	650.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,432.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	261.00	0.00
IV THERAPY	144.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	217.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,184.00	167.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,405.00	865.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	111.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,847.50	1,070.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,847.50	1,070.00

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	205,322.36	ADJUSTMENTS	1,032.00
COVERED CHARGES	186,492.36	CONTRACTUAL ALLOW	163,192.36
NON-COVERED CHARGES	18,830.00	TOTAL MEDICAID LIAB	23,300.00
		LESS: COB	17.50
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	22,664.50

TOTAL NUMBER OF CLAIMS 466

OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,873.50	415.50
MED/SURG SUPPLY	3,121.12	0.00
LABORATORY-GENERAL	33,690.77	4,270.00
RADIOLOGY-DIAGNOSTIC	12,785.75	0.00
CT SCAN	1,637.00	1,541.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	261.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	903.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	104,680.50	11,959.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,994.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	644.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	576.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,968.47	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	186,492.36	18,830.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	186,492.36	18,830.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,088.75	ADJUSTMENTS	0.00
COVERED CHARGES	2,088.75	CONTRACTUAL ALLOW	511.71
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	1,577.04
		LESS: COB	1,571.04
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391.75	0.00
MED/SURG SUPPLY	4.00	0.00
LABORATORY-GENERAL	128.50	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,546.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,088.75	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,088.75	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST

REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	366,647.71	ADJUSTMENTS	78,480.91
COVERED CHARGES	300,948.26	CONTRACTUAL ALLOW	179,909.94
NON-COVERED CHARGES	65,699.45	TOTAL MEDICAID LIAB	121,038.32
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	120,996.32

TOTAL NUMBER OF CLAIMS 37

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST
REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP93

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,889.20	5,063.65
MED/SURG SUPPLY	55,101.98	0.00
LABORATORY-GENERAL	0.00	43.50
RADIOLOGY-DIAGNOSTIC	4,385.50	0.00
CT SCAN	33,621.50	7,734.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,532.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	78,246.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,885.00	0.00
ANESTHESIA	15,983.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,907.50	547.50
RECOVERY ROOM	20,241.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	535.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,134.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,600.58	6,401.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	40,972.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,883.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,937.00

TOTAL ANCILLARY	300,948.26	65,699.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	300,948.26	65,699.45

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL COMMUNITY HOSPITAL
247 SOUTH MAIN ST

REIDSVILLE GA 30453-4605

PROVIDER NUMBER 000001878A
NUMBER OF BEDS 25
TITLE XVIII NO: HOSP93

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,657,601.80	ADJUSTMENTS	25,594.47
COVERED CHARGES	3,532,350.49	CONTRACTUAL ALLOW	959,824.04
NON-COVERED CHARGES	125,251.31	TOTAL MEDICAID LIAB	2,572,526.45
		LESS: COB	43,043.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,529,482.65

TOTAL NUMBER OF ADMISSIONS 802

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,327	276	411,370.00	118,570.00
NURSERY CARE CHARGES	488	0	98,370.00	4,130.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,815	276	509,740.00	122,700.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	107	0	96,300.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	107	0	96,300.00	0.00
TOTAL ACCOMODATIONS	1,922	276	606,040.00	122,700.00

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	847,031.23	0.00
MED/SURG SUPPLY	415,866.61	536.31
LABORATORY-GENERAL	318,610.80	351.00
RADIOLOGY-DIAGNOSTIC	48,975.00	0.00
CT SCAN	64,050.00	0.00
PHYSICAL THERAPY	19,420.00	0.00
EKG/ECG	16,760.00	0.00
IV THERAPY	220.00	0.00
OPERATING ROOM	671,821.20	0.00
LABOR/DELIVERY ROOM	34,919.00	0.00
RESPIRATORY SERVICES	85,566.00	0.00
ANESTHESIA	159,182.00	0.00
GI SERVICES	35,307.00	0.00
EMERGENCY ROOM	34,714.43	0.00
RECOVERY ROOM	33,000.00	0.00
LABORATORY PATHOLOGIC	10,857.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	300.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,200.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,654.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,750.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,690.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,677.12	0.00
OTHER LAB SERVICES	3,080.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,022.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	324.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,937.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,040.00

TOTAL ANCILLARY	2,926,310.49	2,551.31
TOTAL ACCOMODATIONS	606,040.00	122,700.00
TOTAL CHARGES	3,532,350.49	125,251.31

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	54,044.10	ADJUSTMENTS	0.00
COVERED CHARGES	49,184.10	CONTRACTUAL ALLOW	4,715.06
NON-COVERED CHARGES	4,860.00	TOTAL MEDICAID LIAB	44,469.04
		LESS: COB	44,469.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16	10	4,960.00	4,270.00
NURSERY CARE CHARGES	1	0	310.00	590.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	10	5,270.00	4,860.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	17	10	5,270.00	4,860.00

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,164.50	0.00
MED/SURG SUPPLY	5,331.10	0.00
LABORATORY-GENERAL	4,414.00	0.00
RADIOLOGY-DIAGNOSTIC	620.00	0.00
CT SCAN	680.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	14,712.00	0.00
LABOR/DELIVERY ROOM	706.00	0.00
RESPIRATORY SERVICES	425.00	0.00
ANESTHESIA	4,356.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	285.00	0.00
RECOVERY ROOM	775.00	0.00
LABORATORY PATHOLOGIC	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,387.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,914.10	0.00
TOTAL ACCOMODATIONS	5,270.00	4,860.00
TOTAL CHARGES	49,184.10	4,860.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,234,768.31	ADJUSTMENTS	52,739.39
COVERED CHARGES	4,873,833.58	CONTRACTUAL ALLOW	3,470,005.84
NON-COVERED CHARGES	360,934.73	TOTAL MEDICAID LIAB	1,403,827.74
		LESS: COB	1,605.47
		LESS: COPAYMENT	8,241.00
		REIMBURSEMENT	1,393,981.27
		ALL OTHER	1,234,528.03
		FEE SCHEDULE-LAB	159,453.24
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8,968

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352,467.78	50,249.26
MED/SURG SUPPLY	221,512.09	2,065.60
LABORATORY-GENERAL	0.00	26,490.13
RADIOLOGY-DIAGNOSTIC	268,035.00	8,790.00
CT SCAN	317,600.00	5,512.64
PHYSICAL THERAPY	34,906.70	700.00
EKG/ECG	27,672.00	530.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,185,988.27	72,882.50
LABOR/DELIVERY ROOM	134.00	0.00
RESPIRATORY SERVICES	32,712.00	119.00
ANESTHESIA	256,978.00	36.00
GI SERVICES	56,949.00	2,537.00
EMERGENCY ROOM	243,910.66	2,993.00
RECOVERY ROOM	62,680.00	0.00
LABORATORY PATHOLOGIC	0.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	19,808.00	0.00
OTHER IMAGING SERVICES	194,028.00	16,230.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,064.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	81,557.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	109,759.00	1,361.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	419,739.15	8,135.00
OTHER LAB SERVICES	6,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	761,706.93	156,769.60
MRI SERVICES	219,140.00	1,779.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	539.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	120.00

TOTAL ANCILLARY	4,873,833.58	359,974.73
TOTAL ACCOMODATIONS	0.00	960.00
TOTAL CHARGES	4,873,833.58	360,934.73

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	194,777.28	ADJUSTMENTS	0.00
COVERED CHARGES	175,732.20	CONTRACTUAL ALLOW	31,030.05
NON-COVERED CHARGES	19,045.08	TOTAL MEDICAID LIAB	144,702.15
		LESS: COB	144,537.15
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	0.00
		ALL OTHER	5,140.91-
		FEE SCHEDULE-LAB	5,140.91
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 258

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,334.00	1,764.50
MED/SURG SUPPLY	12,787.83	47.00
LABORATORY-GENERAL	0.00	978.58
RADIOLOGY-DIAGNOSTIC	8,650.00	454.00
CT SCAN	11,030.00	0.00
PHYSICAL THERAPY	800.00	0.00
EKG/ECG	1,696.00	66.00
IV THERAPY	0.00	0.00
OPERATING ROOM	35,547.00	6,458.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,262.00	93.00
ANESTHESIA	8,934.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,620.72	0.00
RECOVERY ROOM	1,860.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,540.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,321.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,375.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,590.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,006.25	0.00
OTHER LAB SERVICES	680.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,541.40	6,328.00
MRI SERVICES	9,478.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	485.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	50.00

TOTAL ANCILLARY	175,732.20	19,045.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	175,732.20	19,045.08

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	134,064.46	ADJUSTMENTS	1,029.00
COVERED CHARGES	131,421.46	CONTRACTUAL ALLOW	102,011.46
NON-COVERED CHARGES	2,643.00	TOTAL MEDICAID LIAB	29,410.00
		LESS: COB	164.00
		LESS: COPAYMENT	495.00
		REIMBURSEMENT	28,751.00

TOTAL NUMBER OF CLAIMS 599

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,479.10	523.00
MED/SURG SUPPLY	3,229.78	115.00
LABORATORY-GENERAL	16,232.00	1,730.00
RADIOLOGY-DIAGNOSTIC	11,300.00	0.00
CT SCAN	7,150.00	0.00
PHYSICAL THERAPY	300.00	0.00
EKG/ECG	412.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,194.00	0.00
ANESTHESIA	1,057.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	59,550.08	275.00
RECOVERY ROOM	360.00	0.00
LABORATORY PATHOLOGIC	225.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,240.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,332.50	0.00
OTHER LAB SERVICES	360.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	131,421.46	2,643.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	131,421.46	2,643.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,731.50	ADJUSTMENTS	0.00
COVERED CHARGES	5,285.50	CONTRACTUAL ALLOW	2,047.73
NON-COVERED CHARGES	446.00	TOTAL MEDICAID LIAB	3,237.77
		LESS: COB	3,222.77
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,106.00	0.00
MED/SURG SUPPLY	340.50	0.00
LABORATORY-GENERAL	699.00	446.00
RADIOLOGY-DIAGNOSTIC	920.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	136.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	277.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,562.00	0.00
RECOVERY ROOM	120.00	0.00
LABORATORY PATHOLOGIC	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	100.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,285.50	446.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,285.50	446.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,077.15	ADJUSTMENTS	0.00
COVERED CHARGES	20,038.15	CONTRACTUAL ALLOW	12,165.39
NON-COVERED CHARGES	39.00	TOTAL MEDICAID LIAB	7,872.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,872.76

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,601.00	0.00
MED/SURG SUPPLY	3,442.15	39.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	100.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,035.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,560.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	300.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	20,038.15	39.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,038.15	39.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
MACON HIGHWAY	000001548A	55	SERVICE DATES 04/01/2004 THROUGH 03/31/2005

TITLE XVIII NO: HOSP27

HAWKINSVLE GA 31036-0000

****** NO DATA ******

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,824,821.17	ADJUSTMENTS	22,827.56
COVERED CHARGES	3,690,616.81	CONTRACTUAL ALLOW	1,101,846.04
NON-COVERED CHARGES	134,204.36	TOTAL MEDICAID LIAB	2,588,770.77
		LESS: COB	44,230.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,544,539.82

TOTAL NUMBER OF ADMISSIONS 858

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,396	298	432,760.00	125,290.00
NURSERY CARE CHARGES	578	0	116,810.00	6,490.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,974	298	549,570.00	131,780.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	91	0	81,900.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	91	0	81,900.00	0.00
TOTAL ACCOMODATIONS	2,065	298	631,470.00	131,780.00

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	808,495.75	0.00
MED/SURG SUPPLY	513,238.30	828.36
LABORATORY-GENERAL	319,512.66	415.00
RADIOLOGY-DIAGNOSTIC	51,654.00	0.00
CT SCAN	50,640.00	0.00
PHYSICAL THERAPY	12,990.00	0.00
EKG/ECG	14,138.00	0.00
IV THERAPY	220.00	0.00
OPERATING ROOM	693,474.00	0.00
LABOR/DELIVERY ROOM	36,914.00	0.00
RESPIRATORY SERVICES	143,954.00	0.00
ANESTHESIA	149,221.00	0.00
GI SERVICES	18,259.00	0.00
EMERGENCY ROOM	50,057.88	0.00
RECOVERY ROOM	34,790.00	0.00
LABORATORY PATHOLOGIC	8,797.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,190.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,604.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,295.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,224.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	73,388.51	0.00
OTHER LAB SERVICES	4,560.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,429.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,181.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,100.71	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,059,146.81	2,424.36
TOTAL ACCOMODATIONS	631,470.00	131,780.00
TOTAL CHARGES	3,690,616.81	134,204.36

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	211,598.35	ADJUSTMENTS	0.00
COVERED CHARGES	199,008.35	CONTRACTUAL ALLOW	5,920.90
NON-COVERED CHARGES	12,590.00	TOTAL MEDICAID LIAB	193,087.45
		LESS: COB	193,087.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	49	32	15,190.00	12,590.00
NURSERY CARE CHARGES	6	0	1,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	55	32	16,390.00	12,590.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	4	0	3,600.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	3,600.00	0.00
TOTAL ACCOMODATIONS	59	32	19,990.00	12,590.00

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,740.30	0.00
MED/SURG SUPPLY	27,215.80	0.00
LABORATORY-GENERAL	15,274.00	0.00
RADIOLOGY-DIAGNOSTIC	900.00	0.00
CT SCAN	6,120.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	302.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	60,243.00	0.00
LABOR/DELIVERY ROOM	1,716.00	0.00
RESPIRATORY SERVICES	3,774.00	0.00
ANESTHESIA	13,889.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	920.00	0.00
RECOVERY ROOM	2,075.00	0.00
LABORATORY PATHOLOGIC	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	240.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	66.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	600.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,480.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	485.00	0.00
OTHER LAB SERVICES	280.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	673.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	179,018.35	0.00
TOTAL ACCOMODATIONS	19,990.00	12,590.00
TOTAL CHARGES	199,008.35	12,590.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,652,396.02	ADJUSTMENTS	8,144.54
COVERED CHARGES	5,347,667.95	CONTRACTUAL ALLOW	4,144,849.02
NON-COVERED CHARGES	304,728.07	TOTAL MEDICAID LIAB	1,202,818.93
		LESS: COB	395.78
		LESS: COPAYMENT	6,459.00
		REIMBURSEMENT	1,195,964.15
		ALL OTHER	1,026,491.49
		FEE SCHEDULE-LAB	169,472.66
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9,041

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	466,477.75	21,029.87
MED/SURG SUPPLY	335,549.65	2,209.08
LABORATORY-GENERAL	288.00	34,458.67
RADIOLOGY-DIAGNOSTIC	280,408.00	4,402.00
CT SCAN	275,230.00	9,350.00
PHYSICAL THERAPY	42,576.85	1,125.00
EKG/ECG	36,501.54	420.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,180,276.97	59,213.95
LABOR/DELIVERY ROOM	670.00	0.00
RESPIRATORY SERVICES	63,781.00	563.00
ANESTHESIA	278,065.00	0.00
GI SERVICES	84,829.00	0.00
EMERGENCY ROOM	271,985.37	1,445.00
RECOVERY ROOM	62,705.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	450.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	49,016.00	0.00
OTHER IMAGING SERVICES	158,399.00	4,140.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,160.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	74,858.00	280.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	99,154.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	8,110.00
TREATMENT/OBSERVATION	560,083.16	2,642.50
OTHER LAB SERVICES	5,700.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	826,619.66	148,380.50
MRI SERVICES	194,044.00	3,806.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	992.50

TOTAL ANCILLARY	5,347,667.95	304,728.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,347,667.95	304,728.07

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	255,224.68	ADJUSTMENTS	0.00
COVERED CHARGES	240,615.12	CONTRACTUAL ALLOW	39,933.61
NON-COVERED CHARGES	14,609.56	TOTAL MEDICAID LIAB	200,681.51
		LESS: COB	200,552.51
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	0.00
		ALL OTHER	7,257.15-
		FEE SCHEDULE-LAB	7,257.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 361

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,120.47	1,102.14
MED/SURG SUPPLY	15,912.65	25.50
LABORATORY-GENERAL	0.00	2,738.72
RADIOLOGY-DIAGNOSTIC	6,710.00	0.00
CT SCAN	16,810.00	680.00
PHYSICAL THERAPY	4,150.00	0.00
EKG/ECG	342.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,765.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,102.00	0.00
ANESTHESIA	12,578.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,525.00	0.00
RECOVERY ROOM	2,100.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	75.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,030.00	480.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,416.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,220.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,157.50	379.50
OTHER LAB SERVICES	400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,818.50	8,477.70
MRI SERVICES	15,383.00	726.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	240,615.12	14,609.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	240,615.12	14,609.56

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	171,038.91	ADJUSTMENTS	150.00
COVERED CHARGES	163,899.96	CONTRACTUAL ALLOW	128,669.96
NON-COVERED CHARGES	7,138.95	TOTAL MEDICAID LIAB	35,230.00
		LESS: COB	300.65
		LESS: COPAYMENT	783.00
		REIMBURSEMENT	34,146.35

TOTAL NUMBER OF CLAIMS 714

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,329.06	0.00
MED/SURG SUPPLY	3,772.99	297.00
LABORATORY-GENERAL	29,819.00	2,449.00
RADIOLOGY-DIAGNOSTIC	13,212.00	0.00
CT SCAN	4,760.00	680.00
PHYSICAL THERAPY	550.00	0.00
EKG/ECG	687.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,687.00	3,267.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,567.00	0.00
ANESTHESIA	1,057.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	70,091.41	205.00
RECOVERY ROOM	240.00	0.00
LABORATORY PATHOLOGIC	475.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,320.00	240.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,332.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	163,899.96	7,138.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	163,899.96	7,138.95

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,529.90	ADJUSTMENTS	0.00
COVERED CHARGES	5,406.90	CONTRACTUAL ALLOW	1,252.93
NON-COVERED CHARGES	123.00	TOTAL MEDICAID LIAB	4,153.97
		LESS: COB	4,144.97
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	747.90	0.00
MED/SURG SUPPLY	743.50	0.00
LABORATORY-GENERAL	928.00	103.00
RADIOLOGY-DIAGNOSTIC	190.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,425.00	20.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	240.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,132.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,406.90	123.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,406.90	123.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
MACON HIGHWAY	000001548A	55	SERVICE DATES 04/01/2005 THROUGH 03/31/2006
	TITLE XVIII NO: HOSP27		
HAWKINSVLE GA 31036-0000			

****** NO DATA ******

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,746,027.53	ADJUSTMENTS	15,182.49
COVERED CHARGES	1,701,771.24	CONTRACTUAL ALLOW	478,777.27
NON-COVERED CHARGES	44,256.29	TOTAL MEDICAID LIAB	1,222,993.97
		LESS: COB	10,989.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,212,004.15

TOTAL NUMBER OF ADMISSIONS 350

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	710	78	220,100.00	35,690.00
NURSERY CARE CHARGES	217	0	44,720.00	7,080.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	927	78	264,820.00	42,770.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	54	0	49,500.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	54	0	49,500.00	0.00
TOTAL ACCOMODATIONS	981	78	314,320.00	42,770.00

INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,659.68	0.00
MED/SURG SUPPLY	238,267.69	194.29
LABORATORY-GENERAL	162,927.00	107.00
RADIOLOGY-DIAGNOSTIC	25,972.00	0.00
CT SCAN	37,430.00	0.00
PHYSICAL THERAPY	11,690.00	0.00
EKG/ECG	8,684.00	0.00
IV THERAPY	88.00	0.00
OPERATING ROOM	317,350.00	0.00
LABOR/DELIVERY ROOM	10,748.00	0.00
RESPIRATORY SERVICES	65,358.00	0.00
ANESTHESIA	60,090.00	0.00
GI SERVICES	13,685.00	0.00
EMERGENCY ROOM	32,035.92	0.00
RECOVERY ROOM	17,900.00	0.00
LABORATORY PATHOLOGIC	875.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,240.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,591.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,750.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,400.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,736.95	0.00
OTHER LAB SERVICES	2,360.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,321.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,084.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,292.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	101.00

TOTAL ANCILLARY	1,387,451.24	1,486.29
TOTAL ACCOMODATIONS	314,320.00	42,770.00
TOTAL CHARGES	1,701,771.24	44,256.29

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	62,669.29	ADJUSTMENTS	0.00
COVERED CHARGES	58,604.29	CONTRACTUAL ALLOW	3,196.39
NON-COVERED CHARGES	4,065.00	TOTAL MEDICAID LIAB	55,407.90
		LESS: COB	55,407.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	13	9	4,030.00	3,540.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	9	4,030.00	3,540.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	5	0	4,500.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,500.00	0.00
TOTAL ACCOMODATIONS	18	9	8,530.00	3,540.00

ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,930.34	0.00
MED/SURG SUPPLY	7,517.95	0.00
LABORATORY-GENERAL	4,485.00	0.00
RADIOLOGY-DIAGNOSTIC	290.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	132.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,150.00	0.00
LABOR/DELIVERY ROOM	572.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	4,344.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	900.00	0.00
RECOVERY ROOM	1,675.00	0.00
LABORATORY PATHOLOGIC	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,053.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	525.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	50,074.29	525.00
TOTAL ACCOMODATIONS	8,530.00	3,540.00
TOTAL CHARGES	58,604.29	4,065.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	2,419,364.03	ADJUSTMENTS	2,454.49
COVERED CHARGES	2,258,862.25	CONTRACTUAL ALLOW	1,756,029.81
NON-COVERED CHARGES	160,501.78	TOTAL MEDICAID LIAB	502,832.44
		LESS: COB	1,641.05
		LESS: COPAYMENT	3,486.00
		REIMBURSEMENT	497,705.39
		ALL OTHER	418,455.87
		FEE SCHEDULE-LAB	79,249.52
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,760

OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,419.33	4,014.85
MED/SURG SUPPLY	129,555.44	1,506.10
LABORATORY-GENERAL	0.00	28,106.68
RADIOLOGY-DIAGNOSTIC	108,736.00	5,990.00
CT SCAN	126,960.00	8,420.00
PHYSICAL THERAPY	11,886.90	0.00
EKG/ECG	17,097.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	457,576.08	8,560.00
LABOR/DELIVERY ROOM	4,012.50	37.50
RESPIRATORY SERVICES	21,048.00	40.00
ANESTHESIA	104,501.00	0.00
GI SERVICES	29,987.00	4,829.00
EMERGENCY ROOM	145,904.56	910.00
RECOVERY ROOM	22,680.00	0.00
LABORATORY PATHOLOGIC	0.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	63,714.00	2,875.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	500.00	626.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	56,659.00	1,706.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,865.00	740.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	4,978.00
TREATMENT/OBSERVATION	305,555.44	2,507.50
OTHER LAB SERVICES	3,640.00	400.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	398,705.00	79,947.65
MRI SERVICES	65,710.00	4,213.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	69.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,258,862.25	160,501.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,258,862.25	160,501.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	93,300.80	ADJUSTMENTS	0.00
COVERED CHARGES	86,719.55	CONTRACTUAL ALLOW	18,213.59
NON-COVERED CHARGES	6,581.25	TOTAL MEDICAID LIAB	68,505.96
		LESS: COB	68,451.96
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,825.75-
		FEE SCHEDULE-LAB	2,825.75
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 127

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,415.39	11.00
MED/SURG SUPPLY	5,500.80	154.50
LABORATORY-GENERAL	0.00	1,592.00
RADIOLOGY-DIAGNOSTIC	4,120.00	0.00
CT SCAN	4,080.00	1,360.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	66.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	31,109.00	0.00
LABOR/DELIVERY ROOM	312.50	0.00
RESPIRATORY SERVICES	137.00	0.00
ANESTHESIA	7,800.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,617.56	0.00
RECOVERY ROOM	1,200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,200.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,855.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	304.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,802.50	117.50
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,473.80	3,346.25
MRI SERVICES	726.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,719.55	6,581.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,719.55	6,581.25

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	77,703.51	ADJUSTMENTS	122.00
COVERED CHARGES	74,142.41	CONTRACTUAL ALLOW	58,377.41
NON-COVERED CHARGES	3,561.10	TOTAL MEDICAID LIAB	15,765.00
		LESS: COB	118.52
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	15,127.48

TOTAL NUMBER OF CLAIMS 322

OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,688.03	0.00
MED/SURG SUPPLY	1,275.50	286.10
LABORATORY-GENERAL	14,522.00	1,945.00
RADIOLOGY-DIAGNOSTIC	7,160.00	330.00
CT SCAN	3,400.00	680.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	136.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	86.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	314.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,178.38	55.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	175.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	720.00	240.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,487.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	74,142.41	3,561.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,142.41	3,561.10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	2,942.41	ADJUSTMENTS	0.00
COVERED CHARGES	2,827.41	CONTRACTUAL ALLOW	844.36
NON-COVERED CHARGES	115.00	TOTAL MEDICAID LIAB	1,983.05
		LESS: COB	1,983.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONALHOSP
MACON HIGHWAY
HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP27

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	515.91	0.00
MED/SURG SUPPLY	60.50	0.00
LABORATORY-GENERAL	886.00	115.00
RADIOLOGY-DIAGNOSTIC	500.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	825.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,827.41	115.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,827.41	115.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP
MACON HIGHWAY

HAWKINSVLE GA 31036-0000

PROVIDER NUMBER 000001548A
NUMBER OF BEDS 55
TITLE XVIII NO: HOSP27

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONALHOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
MACON HIGHWAY	000001548A	55	SERVICE DATES 04/01/2006 THROUGH 03/31/2007
	TITLE XVIII NO: HOSP27		
HAWKINSVLE GA 31036-0000			

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	55,600,720.38	ADJUSTMENTS	5,095,926.66
COVERED CHARGES	54,234,856.98	CONTRACTUAL ALLOW	27,335,507.25
NON-COVERED CHARGES	1,365,863.40	TOTAL MEDICAID LIAB	26,899,349.73
		LESS: COB	202,452.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,696,897.38

TOTAL NUMBER OF ADMISSIONS 5,080

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	15,082	7	6,409,775.00	683,400.00
NURSERY CARE CHARGES	4,214	0	1,429,120.00	175,420.00
SWING BED	0	2	0.00	106.00
LEAVE OF ABSENCE	0	40	0.00	0.00
TOTAL ROUTINE	19,296	49	7,838,895.00	858,926.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1,139	0	1,195,975.00	0.00
N I C U	3,986	0	4,116,300.00	0.00
PED I C U	239	0	245,825.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,364	0	5,558,100.00	0.00
TOTAL ACCOMODATIONS	24,660	49	13,396,995.00	858,926.00

INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,812,607.70	0.00
MED/SURG SUPPLY	6,815,655.34	186,244.00
LABORATORY-GENERAL	7,040,727.46	0.00
RADIOLOGY-DIAGNOSTIC	717,953.00	0.00
CT SCAN	813,115.35	1,060.00
PHYSICAL THERAPY	200,781.00	0.00
EKG/ECG	330,345.00	0.00
IV THERAPY	10,237.00	0.00
OPERATING ROOM	1,490,831.50	0.00
LABOR/DELIVERY ROOM	2,244,315.00	0.00
RESPIRATORY SERVICES	1,948,659.50	0.00
ANESTHESIA	525,789.00	0.00
GI SERVICES	6,691.00	0.00
EMERGENCY ROOM	491,528.00	0.00
RECOVERY ROOM	349,614.00	0.00
LABORATORY PATHOLOGIC	286,665.00	0.00
RADIOLOGY THERAPEUTIC	96,157.00	0.00
OCCUPATIONAL THERAPY	61,511.00	0.00
SPEECH PATHOLOGY	40,408.00	0.00
RENAL DIALYSIS	177,091.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,557.00
PSYCHIATRIC SERVICES	137,990.00	0.00
LITHOTRIPSY	7,442.00	0.00
OTHER IMAGING SERVICES	232,056.00	0.00
BLOOD	5,217.00	0.00
BLOOD STORAGE & PRO.	2,376,808.00	48,190.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	121,448.00	0.00
AUDIOLOGY	552.00	30,532.00
CARDIOLOGY	474,108.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	36,600.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	51,693.85	45,439.00
OTHER LAB SERVICES	162,067.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	259.75	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	242,909.00	1,862.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	19.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	119,859.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,528,029.53	1,894.25
HOME HEALTH SERVICES	0.00	215.15
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	69,066.00

TOTAL ANCILLARY	40,837,861.98	506,937.40
TOTAL ACCOMODATIONS	13,396,995.00	858,926.00
TOTAL CHARGES	54,234,856.98	1,365,863.40

ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,631,971.85	ADJUSTMENTS	0.00
COVERED CHARGES	1,573,452.85	CONTRACTUAL ALLOW	115,823.52
NON-COVERED CHARGES	58,519.00	TOTAL MEDICAID LIAB	1,457,629.33
		LESS: COB	1,457,629.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 148

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	520	0	221,000.00	22,420.00
NURSERY CARE CHARGES	165	0	62,745.00	17,310.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	685	0	283,745.00	39,730.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	10	0	10,250.00	0.00
N I C U	108	0	112,650.00	0.00
PED I C U	2	0	2,150.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	120	0	125,050.00	0.00
TOTAL ACCOMODATIONS	805	0	408,795.00	39,730.00

ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	257,344.60	0.00
MED/SURG SUPPLY	253,544.65	9,054.00
LABORATORY-GENERAL	171,129.00	0.00
RADIOLOGY-DIAGNOSTIC	13,454.00	0.00
CT SCAN	24,198.00	223.00
PHYSICAL THERAPY	2,913.00	0.00
EKG/ECG	5,852.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,028.00	0.00
LABOR/DELIVERY ROOM	146,262.00	0.00
RESPIRATORY SERVICES	42,091.00	0.00
ANESTHESIA	26,183.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,654.00	0.00
RECOVERY ROOM	5,490.00	0.00
LABORATORY PATHOLOGIC	12,355.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,714.00	0.00
SPEECH PATHOLOGY	582.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,796.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	51,707.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,212.00	0.00
AUDIOLOGY	0.00	1,118.00
CARDIOLOGY	17,534.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	538.90	1,062.00
OTHER LAB SERVICES	699.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,183.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	5,832.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	86,193.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,500.00

TOTAL ANCILLARY	1,164,657.85	18,789.00
TOTAL ACCOMODATIONS	408,795.00	39,730.00
TOTAL CHARGES	1,573,452.85	58,519.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,718,131.43	ADJUSTMENTS	1,301,553.10
COVERED CHARGES	18,524,270.34	CONTRACTUAL ALLOW	10,914,258.12
NON-COVERED CHARGES	1,193,861.09	TOTAL MEDICAID LIAB	7,610,012.22
		LESS: COB	6,760.28
		LESS: COPAYMENT	29,556.00
		REIMBURSEMENT	7,573,695.94
		ALL OTHER	6,946,751.10
		FEE SCHEDULE-LAB	575,740.07
		INJECTABLE DRUGS	51,204.77

TOTAL NUMBER OF CLAIMS 30,558

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,411,470.26	36,071.25
MED/SURG SUPPLY	1,321,689.82	9,046.82
LABORATORY-GENERAL	2,052.00	48,691.60
RADIOLOGY-DIAGNOSTIC	717,844.75	20,900.00
CT SCAN	891,232.00	9,358.00
PHYSICAL THERAPY	281,723.00	12,695.00
EKG/ECG	128,352.75	334.00
IV THERAPY	101,996.00	0.00
OPERATING ROOM	1,452,433.32	63,882.66
LABOR/DELIVERY ROOM	340,748.00	1,098.00
RESPIRATORY SERVICES	198,738.90	3,850.00
ANESTHESIA	209,105.00	1,877.00
GI SERVICES	19,586.00	0.00
EMERGENCY ROOM	2,091,162.25	4,118.00
RECOVERY ROOM	647,721.00	4,287.00
LABORATORY PATHOLOGIC	0.00	151.00
RADIOLOGY THERAPEUTIC	549,542.10	8,737.00
OCCUPATIONAL THERAPY	118,757.00	4,306.00
SPEECH PATHOLOGY	818,337.00	822.00
RENAL DIALYSIS	0.00	12,192.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	465,619.10	2,875.00
PSYCHIATRIC SERVICES	545.00	1,728.00
LITHOTRIPSY	15,256.00	0.00
OTHER IMAGING SERVICES	766,319.00	30,297.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	116,220.00	90,636.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	235,663.90	2,872.00
AUDIOLOGY	161,099.00	0.00
CARDIOLOGY	200,412.00	4,343.00
AMBULATORY SURGERY	15,699.60	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	251,499.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,194,107.67	37,454.65
OTHER LAB SERVICES	170,355.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,797.25	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,042,273.34	480,346.70
MRI SERVICES	476,625.00	26,564.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	20.00
DURABLE MEDICAL EQUIPME	0.00	48.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	107,108.33	242,413.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	180.00	29,672.00

TOTAL ANCILLARY	18,524,270.34	1,191,687.09
TOTAL ACCOMODATIONS	0.00	2,174.00
TOTAL CHARGES	18,524,270.34	1,193,861.09

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,902.53	ADJUSTMENTS	0.00
COVERED CHARGES	65,316.83	CONTRACTUAL ALLOW	21,531.11
NON-COVERED CHARGES	2,585.70	TOTAL MEDICAID LIAB	43,785.72
		LESS: COB	43,737.72
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,631.63-
		FEE SCHEDULE-LAB	1,595.70
		INJECTABLE DRUGS	35.93

TOTAL NUMBER OF CLAIMS 92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,444.37	0.00
MED/SURG SUPPLY	6,240.75	0.00
LABORATORY-GENERAL	0.00	135.00
RADIOLOGY-DIAGNOSTIC	1,651.00	0.00
CT SCAN	4,256.00	0.00
PHYSICAL THERAPY	437.00	0.00
EKG/ECG	196.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,419.00	0.00
LABOR/DELIVERY ROOM	2,916.00	0.00
RESPIRATORY SERVICES	223.00	0.00
ANESTHESIA	2,272.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,541.00	0.00
RECOVERY ROOM	6,345.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,921.00	213.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	299.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,312.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	404.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,455.10	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,067.46	1,301.80
MRI SERVICES	1,985.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	81.15	636.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	65,316.83	2,585.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,316.83	2,585.70

OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	451,364.11	ADJUSTMENTS	4,761.44
COVERED CHARGES	437,750.78	CONTRACTUAL ALLOW	364,466.60
NON-COVERED CHARGES	13,613.33	TOTAL MEDICAID LIAB	73,284.18
		LESS: COB	67.56
		LESS: COPAYMENT	1,113.00
		REIMBURSEMENT	72,103.62

TOTAL NUMBER OF CLAIMS 1,294

OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,887.46	93.40
MED/SURG SUPPLY	9,844.25	274.00
LABORATORY-GENERAL	49,555.00	6,030.00
RADIOLOGY-DIAGNOSTIC	19,089.00	532.00
CT SCAN	8,680.00	0.00
PHYSICAL THERAPY	1,362.00	0.00
EKG/ECG	1,965.00	0.00
IV THERAPY	2,085.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	286.00	0.00
RESPIRATORY SERVICES	1,126.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	266,176.25	440.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,608.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,370.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,068.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,657.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,290.00	0.00
OTHER LAB SERVICES	3,412.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,231.62	0.00
MRI SERVICES	3,700.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,358.20	6,243.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	437,750.78	13,613.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	437,750.78	13,613.33

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,942.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,885.50	CONTRACTUAL ALLOW	735.99
NON-COVERED CHARGES	56.90	TOTAL MEDICAID LIAB	1,149.51
		LESS: COB	1,149.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	6.00	0.00
LABORATORY-GENERAL	369.00	7.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,510.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	49.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,885.50	56.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,885.50	56.90

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,738,245.56	ADJUSTMENTS	320,542.64
COVERED CHARGES	2,619,392.00	CONTRACTUAL ALLOW	1,839,140.40
NON-COVERED CHARGES	118,853.56	TOTAL MEDICAID LIAB	780,251.60
		LESS: COB	649.80
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	779,013.80

TOTAL NUMBER OF CLAIMS 170

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	814,430.66	10,439.84
MED/SURG SUPPLY	200,690.67	44,060.00
LABORATORY-GENERAL	0.00	78.00
RADIOLOGY-DIAGNOSTIC	35,731.00	1,138.00
CT SCAN	17,666.00	1,578.00
PHYSICAL THERAPY	3,800.00	0.00
EKG/ECG	2,458.00	0.00
IV THERAPY	47,081.00	0.00
OPERATING ROOM	157,245.00	0.00
LABOR/DELIVERY ROOM	1,526.00	0.00
RESPIRATORY SERVICES	21,948.00	1,820.00
ANESTHESIA	16,896.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,095.00	0.00
RECOVERY ROOM	37,708.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	568,857.00	13,994.00
OCCUPATIONAL THERAPY	158.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,197.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	51,354.00	360.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	14,884.00	0.00
OTHER IMAGING SERVICES	605.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,572.00	8,420.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,325.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,556.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	73,443.85	1,152.00
OTHER LAB SERVICES	6,876.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	413,081.94	7,648.62
MRI SERVICES	3,771.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74,632.88	25,968.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,619,392.00	118,853.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,619,392.00	118,853.56

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	33,287.85	ADJUSTMENTS	0.00
COVERED CHARGES	31,860.90	CONTRACTUAL ALLOW	1,031.00
NON-COVERED CHARGES	1,426.95	TOTAL MEDICAID LIAB	30,829.90
		LESS: COB	30,784.90
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,825.20	417.15
MED/SURG SUPPLY	991.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	17,308.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,551.00	188.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	480.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	146.00	332.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	39.20	9.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	31,860.90	1,426.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,860.90	1,426.95

INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	60,022,625.81	ADJUSTMENTS	5,761,550.33
COVERED CHARGES	59,597,926.03	CONTRACTUAL ALLOW	32,324,943.02
NON-COVERED CHARGES	424,699.78	TOTAL MEDICAID LIAB	27,272,983.01
		LESS: COB	195,908.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,077,074.15

TOTAL NUMBER OF ADMISSIONS 4,828

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	14,735	0	7,072,800.00	29,615.00
NURSERY CARE CHARGES	4,299	0	1,624,960.00	192,980.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	37	0.00	0.00
TOTAL ROUTINE	19,034	37	8,697,760.00	222,595.00
SPECIAL CARE SERVICES				
C C U	19	0	957.00	0.00
I C U	1,206	0	1,296,450.00	0.00
N I C U	4,542	0	4,882,650.00	0.00
PED I C U	269	0	283,800.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,036	0	6,463,857.00	0.00
TOTAL ACCOMODATIONS	25,070	37	15,161,617.00	222,595.00

INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,326,471.35	0.00
MED/SURG SUPPLY	6,848,845.13	13,011.00
LABORATORY-GENERAL	6,932,445.04	0.00
RADIOLOGY-DIAGNOSTIC	714,877.72	0.00
CT SCAN	1,071,726.83	0.00
PHYSICAL THERAPY	184,621.44	0.00
EKG/ECG	340,624.30	0.00
IV THERAPY	3,031.00	0.00
OPERATING ROOM	1,634,466.84	0.00
LABOR/DELIVERY ROOM	3,729,723.80	21,864.00
RESPIRATORY SERVICES	2,685,949.10	0.00
ANESTHESIA	435,663.00	0.00
GI SERVICES	561.00	0.00
EMERGENCY ROOM	591,239.64	0.00
RECOVERY ROOM	324,132.75	0.00
LABORATORY PATHOLOGIC	319,403.06	0.00
RADIOLOGY THERAPEUTIC	132,020.40	0.00
OCCUPATIONAL THERAPY	47,288.85	0.00
SPEECH PATHOLOGY	74,361.00	0.00
RENAL DIALYSIS	217,989.00	935.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,817.15
PSYCHIATRIC SERVICES	170,150.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	313,249.68	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,219,906.64	20,148.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	96,073.08	0.00
AUDIOLOGY	32,395.00	31,875.60
CARDIOLOGY	707,520.84	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	47,341.68	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	41,372.00	15,790.16
OTHER LAB SERVICES	137,165.11	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	251,896.12	3,719.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	21,975.26
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,803,797.63	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	228.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	69,741.61

TOTAL ANCILLARY	44,436,309.03	202,104.78
TOTAL ACCOMODATIONS	15,161,617.00	222,595.00
TOTAL CHARGES	59,597,926.03	424,699.78

ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,607,960.61	ADJUSTMENTS	0.00
COVERED CHARGES	1,593,671.61	CONTRACTUAL ALLOW	55,725.37
NON-COVERED CHARGES	14,289.00	TOTAL MEDICAID LIAB	1,537,946.24
		LESS: COB	1,537,946.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 120

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	526	0	252,480.00	2,285.00
NURSERY CARE CHARGES	99	0	40,480.00	6,875.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	625	0	292,960.00	9,160.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	42	0	45,150.00	0.00
N I C U	76	0	81,700.00	0.00
PED I C U	12	0	12,900.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	130	0	139,750.00	0.00
TOTAL ACCOMODATIONS	755	0	432,710.00	9,160.00

ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234,710.82	0.00
MED/SURG SUPPLY	241,849.82	125.00
LABORATORY-GENERAL	160,767.14	0.00
RADIOLOGY-DIAGNOSTIC	13,849.76	0.00
CT SCAN	20,457.32	0.00
PHYSICAL THERAPY	2,072.76	0.00
EKG/ECG	2,098.44	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	31,856.00	0.00
LABOR/DELIVERY ROOM	236,513.68	655.00
RESPIRATORY SERVICES	53,404.72	0.00
ANESTHESIA	24,488.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,855.68	0.00
RECOVERY ROOM	5,632.00	0.00
LABORATORY PATHOLOGIC	14,002.96	0.00
RADIOLOGY THERAPEUTIC	100.00	0.00
OCCUPATIONAL THERAPY	266.00	0.00
SPEECH PATHOLOGY	1,281.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,862.72	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,504.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	600.00	435.00
CARDIOLOGY	1,273.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	963.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	778.00	0.00
OTHER LAB SERVICES	1,468.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,094.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,914.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64,212.79	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,160,961.61	5,129.00
TOTAL ACCOMODATIONS	432,710.00	9,160.00
TOTAL CHARGES	1,593,671.61	14,289.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	21,394,696.23	ADJUSTMENTS	1,224,409.36
COVERED CHARGES	20,499,825.49	CONTRACTUAL ALLOW	13,596,059.20
NON-COVERED CHARGES	894,870.74	TOTAL MEDICAID LIAB	6,903,766.29
		LESS: COB	6,156.89
		LESS: COPAYMENT	35,193.00
		REIMBURSEMENT	6,862,416.40
		ALL OTHER	6,182,033.53
		FEE SCHEDULE-LAB	678,960.53
		INJECTABLE DRUGS	1,422.34

TOTAL NUMBER OF CLAIMS 29,185

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,802,716.47	7,670.77
MED/SURG SUPPLY	938,797.38	51,715.08
LABORATORY-GENERAL	9,981.44	37,671.36
RADIOLOGY-DIAGNOSTIC	754,485.89	13,752.68
CT SCAN	1,119,476.44	52,375.78
PHYSICAL THERAPY	299,580.00	10,505.92
EKG/ECG	141,389.25	0.00
IV THERAPY	119,181.00	380.00
OPERATING ROOM	1,481,078.08	36,820.44
LABOR/DELIVERY ROOM	372,657.00	378.00
RESPIRATORY SERVICES	316,902.00	5,718.64
ANESTHESIA	142,248.00	0.00
GI SERVICES	3,773.00	0.00
EMERGENCY ROOM	1,844,025.94	2,650.60
RECOVERY ROOM	588,942.00	957.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	789,482.80	25,535.40
OCCUPATIONAL THERAPY	153,303.99	329.92
SPEECH PATHOLOGY	1,241,837.90	0.00
RENAL DIALYSIS	0.00	11,882.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	496,189.49	4,878.40
PSYCHIATRIC SERVICES	1,439.00	0.00
LITHOTRIPSY	7,814.00	0.00
OTHER IMAGING SERVICES	956,592.80	20,536.76
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	208,202.60	15,532.72
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	286,416.37	1,767.00
AUDIOLOGY	126,096.00	0.00
CARDIOLOGY	374,358.96	7,380.00
AMBULATORY SURGERY	9,391.20	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	337,468.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,182,537.57	22,436.00
OTHER LAB SERVICES	184,798.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,484.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,715,094.96	431,230.63
MRI SERVICES	487,790.74	25,700.73
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	175.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,117.00	104,328.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,736.90
TOTAL ANCILLARY	20,499,825.49	894,870.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,499,825.49	894,870.74

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	28,395.60	ADJUSTMENTS	0.00
COVERED CHARGES	24,246.10	CONTRACTUAL ALLOW	7,763.96
NON-COVERED CHARGES	4,149.50	TOTAL MEDICAID LIAB	16,482.14
		LESS: COB	16,407.14
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	478.21-
		FEE SCHEDULE-LAB	434.29
		INJECTABLE DRUGS	43.92

TOTAL NUMBER OF CLAIMS 73

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,689.35	0.00
MED/SURG SUPPLY	1,118.85	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,190.00	0.00
CT SCAN	1,447.04	1,414.56
PHYSICAL THERAPY	941.68	312.48
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,640.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	610.00	0.00
ANESTHESIA	129.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,384.86	0.00
RECOVERY ROOM	1,081.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	432.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	223.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,437.84	236.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	155.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,384.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,320.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,093.88	917.16
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	123.40	1,114.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	24,246.10	4,149.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,246.10	4,149.50

OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	857,552.78	ADJUSTMENTS	29,528.03
COVERED CHARGES	817,252.50	CONTRACTUAL ALLOW	698,711.74
NON-COVERED CHARGES	40,300.28	TOTAL MEDICAID LIAB	118,540.76
		LESS: COB	26.84
		LESS: COPAYMENT	1,809.00
		REIMBURSEMENT	116,704.92

TOTAL NUMBER OF CLAIMS 1,084

OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,009.13	1,800.05
MED/SURG SUPPLY	25,058.75	266.00
LABORATORY-GENERAL	67,109.58	7,827.72
RADIOLOGY-DIAGNOSTIC	23,191.32	0.00
CT SCAN	16,373.40	0.00
PHYSICAL THERAPY	433.44	0.00
EKG/ECG	3,188.88	0.00
IV THERAPY	9,702.00	0.00
OPERATING ROOM	26,850.00	5,555.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,083.84	0.00
ANESTHESIA	2,685.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	232,517.40	0.00
RECOVERY ROOM	21,072.00	0.00
LABORATORY PATHOLOGIC	1,238.00	0.00
RADIOLOGY THERAPEUTIC	43,885.40	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	432.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,822.00	384.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	161.28	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,264.00	155.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	374.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,131.00	3,504.00
OTHER LAB SERVICES	1,716.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	227,899.43	2,730.01
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	54.65	18,078.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	817,252.50	40,300.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	817,252.50	40,300.28

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,644.42	ADJUSTMENTS	0.00
COVERED CHARGES	4,384.42	CONTRACTUAL ALLOW	2,070.06
NON-COVERED CHARGES	260.00	TOTAL MEDICAID LIAB	2,314.36
		LESS: COB	2,311.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	536.50	0.00
MED/SURG SUPPLY	134.00	0.00
LABORATORY-GENERAL	835.84	260.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	115.36	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,683.32	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,384.42	260.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,384.42	260.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET

COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,824,555.32	ADJUSTMENTS	397,546.00
COVERED CHARGES	3,727,958.95	CONTRACTUAL ALLOW	2,766,057.01
NON-COVERED CHARGES	96,596.37	TOTAL MEDICAID LIAB	961,901.94
		LESS: COB	0.00
		LESS: COPAYMENT	2,727.00
		REIMBURSEMENT	959,174.94

TOTAL NUMBER OF CLAIMS 241

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0079GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	524,813.57	743.90
MED/SURG SUPPLY	320,790.00	0.00
LABORATORY-GENERAL	3,043.20	314.00
RADIOLOGY-DIAGNOSTIC	24,162.68	1,444.96
CT SCAN	20,965.72	4,692.00
PHYSICAL THERAPY	814.84	0.00
EKG/ECG	2,321.52	0.00
IV THERAPY	72,024.56	294.00
OPERATING ROOM	197,717.47	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	117,507.00	0.00
ANESTHESIA	12,621.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,991.72	0.00
RECOVERY ROOM	41,728.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	880,423.70	21,987.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,371.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	69,728.00	1,996.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	7,814.00	0.00
OTHER IMAGING SERVICES	7,121.76	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	52,980.36	7,993.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	83,399.04	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	42,877.36	687.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	51,509.09	500.00
OTHER LAB SERVICES	4,916.12	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,172,135.19	10,166.96
MRI SERVICES	5,447.00	3,581.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	106.05	40,825.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,727,958.95	96,596.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,727,958.95	96,596.37

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF COLUMBUS
710 CENTER STREET
COLUMBUS GA 31901-1527

PROVIDER NUMBER 000001196A
NUMBER OF BEDS 417
TITLE XVIII NO: HPH0079GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	21,820,620.52	ADJUSTMENTS	310,158.93
COVERED CHARGES	21,150,051.08	CONTRACTUAL ALLOW	10,682,620.02
NON-COVERED CHARGES	670,569.44	TOTAL MEDICAID LIAB	10,467,431.06
		LESS: COB	36,888.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,430,542.79

TOTAL NUMBER OF ADMISSIONS 3,259

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,947	0	2,317,396.00	411,845.00
NURSERY CARE CHARGES	2,219	0	690,680.00	66,015.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9,166	0	3,008,076.00	477,860.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	522	0	483,255.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	522	0	483,255.00	0.00
TOTAL ACCOMODATIONS	9,688	0	3,491,331.00	477,860.00

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,981,605.59	928.04
MED/SURG SUPPLY	3,557,582.90	0.00
LABORATORY-GENERAL	2,730,724.05	0.00
RADIOLOGY-DIAGNOSTIC	452,440.25	0.00
CT SCAN	550,611.50	4,589.00
PHYSICAL THERAPY	90,103.25	0.00
EKG/ECG	513,892.75	0.00
IV THERAPY	21,546.50	777.95
OPERATING ROOM	1,117,530.32	0.00
LABOR/DELIVERY ROOM	692,309.25	3,746.25
RESPIRATORY SERVICES	739,125.25	0.00
ANESTHESIA	168,627.12	0.00
GI SERVICES	51,350.88	0.00
EMERGENCY ROOM	226,599.75	0.00
RECOVERY ROOM	232,112.10	0.00
LABORATORY PATHOLOGIC	192,158.25	0.00
RADIOLOGY THERAPEUTIC	35,403.00	0.00
OCCUPATIONAL THERAPY	3,277.50	0.00
SPEECH PATHOLOGY	6,343.25	0.00
RENAL DIALYSIS	7,284.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	5,266.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	145,781.50	3,247.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	445,721.75	166,729.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	76,803.00	0.00
AUDIOLOGY	54,014.75	0.00
CARDIOLOGY	312,283.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,785.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	384,710.20	0.00
OTHER LAB SERVICES	55,019.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	801.00	319.75
OTHER THERAPEUTIC SERVI	0.00	2,253.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	112,266.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	182.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,589.75	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	158.65
INJECTABLE DRUGS	671,316.67	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,511.05

TOTAL ANCILLARY	17,658,720.08	192,709.44
TOTAL ACCOMODATIONS	3,491,331.00	477,860.00
TOTAL CHARGES	21,150,051.08	670,569.44

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	419,013.13	ADJUSTMENTS	0.00
COVERED CHARGES	404,821.38	CONTRACTUAL ALLOW	48,115.20
NON-COVERED CHARGES	14,191.75	TOTAL MEDICAID LIAB	356,706.18
		LESS: COB	356,706.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 84

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	150	0	50,250.00	11,255.00
NURSERY CARE CHARGES	49	0	15,705.00	2,850.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	199	0	65,955.00	14,105.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	199	0	65,955.00	14,105.00

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,346.15	0.00
MED/SURG SUPPLY	59,647.25	0.00
LABORATORY-GENERAL	45,264.75	0.00
RADIOLOGY-DIAGNOSTIC	6,435.25	0.00
CT SCAN	6,524.00	0.00
PHYSICAL THERAPY	396.25	0.00
EKG/ECG	11,821.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	31,629.82	0.00
LABOR/DELIVERY ROOM	39,837.75	86.75
RESPIRATORY SERVICES	9,182.25	0.00
ANESTHESIA	4,643.43	0.00
GI SERVICES	1,640.83	0.00
EMERGENCY ROOM	948.75	0.00
RECOVERY ROOM	7,556.16	0.00
LABORATORY PATHOLOGIC	4,746.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,114.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,266.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	824.25	0.00
AUDIOLOGY	1,010.25	0.00
CARDIOLOGY	1,531.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	351.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,636.97	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,440.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,071.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	338,866.38	86.75
TOTAL ACCOMODATIONS	65,955.00	14,105.00
TOTAL CHARGES	404,821.38	14,191.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,441,408.08	ADJUSTMENTS	26,856.33
COVERED CHARGES	13,296,768.20	CONTRACTUAL ALLOW	8,133,457.83
NON-COVERED CHARGES	1,144,639.88	TOTAL MEDICAID LIAB	5,163,310.37
		LESS: COB	13,129.41
		LESS: COPAYMENT	18,117.00
		REIMBURSEMENT	5,132,063.96
		ALL OTHER	4,711,565.37
		FEE SCHEDULE-LAB	396,140.76
		INJECTABLE DRUGS	24,357.83

TOTAL NUMBER OF CLAIMS 18,065

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,033,922.77	38,531.38
MED/SURG SUPPLY	1,497,913.25	40,067.25
LABORATORY-GENERAL	600.00	79,262.75
RADIOLOGY-DIAGNOSTIC	763,456.00	48,517.25
CT SCAN	989,930.00	43,649.23
PHYSICAL THERAPY	93,236.25	12,318.25
EKG/ECG	398,838.75	9,672.00
IV THERAPY	43,045.00	1,160.50
OPERATING ROOM	867,946.47	90,142.52
LABOR/DELIVERY ROOM	555.00	2,104.50
RESPIRATORY SERVICES	130,236.25	3,260.75
ANESTHESIA	141,654.85	1,780.04
GI SERVICES	61,856.03	1,325.74
EMERGENCY ROOM	1,383,417.50	5,773.25
RECOVERY ROOM	316,953.75	3,824.29
LABORATORY PATHOLOGIC	0.00	143.75
RADIOLOGY THERAPEUTIC	119,383.65	5,734.80
OCCUPATIONAL THERAPY	2,191.25	969.75
SPEECH PATHOLOGY	0.00	1,845.75
RENAL DIALYSIS	0.00	77.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	55,060.50	2,400.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	331,725.50	7,224.75
BLOOD	90.50	0.00
BLOOD STORAGE & PRO.	123,576.25	39,183.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	181,615.00	8,334.75
AUDIOLOGY	6,736.25	451.25
CARDIOLOGY	192,152.75	34,292.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	119,181.00	369.75
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	557,633.66	15,719.11
OTHER LAB SERVICES	387,123.00	3,275.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	513.00	0.00
OTHER THERAPEUTIC SERVI	0.00	6,338.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,538,751.79	423,699.63
MRI SERVICES	766,229.25	12,026.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	370.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	6,881.00	1,332.50
FREE STANDING CLINIC	169.25	25.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	184,192.73	199,147.91
HOME HEALTH SERVICES	0.00	17.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	271.23

TOTAL ANCILLARY	13,296,768.20	1,144,639.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,296,768.20	1,144,639.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	270,932.16	ADJUSTMENTS	0.00
COVERED CHARGES	253,155.87	CONTRACTUAL ALLOW	44,612.58
NON-COVERED CHARGES	17,776.29	TOTAL MEDICAID LIAB	208,543.29
		LESS: COB	208,300.29
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	0.00
		ALL OTHER	8,507.77-
		FEE SCHEDULE-LAB	8,379.48
		INJECTABLE DRUGS	128.29

TOTAL NUMBER OF CLAIMS 301

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,752.73	682.09
MED/SURG SUPPLY	26,120.75	28.75
LABORATORY-GENERAL	0.00	3,221.25
RADIOLOGY-DIAGNOSTIC	9,899.25	387.50
CT SCAN	12,062.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	14,624.50	580.50
IV THERAPY	830.50	0.00
OPERATING ROOM	10,915.44	1,582.88
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,068.75	0.00
ANESTHESIA	2,004.13	0.00
GI SERVICES	593.91	0.00
EMERGENCY ROOM	8,426.75	0.00
RECOVERY ROOM	4,197.92	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	147.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	691.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,835.25	714.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,735.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,603.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,505.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,323.16	0.00
OTHER LAB SERVICES	18,629.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	114.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	56,435.75	9,236.50
MRI SERVICES	31,820.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	967.08	1,194.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	253,155.87	17,776.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	253,155.87	17,776.29

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	492,057.83	ADJUSTMENTS	935.00
COVERED CHARGES	476,339.31	CONTRACTUAL ALLOW	379,569.62
NON-COVERED CHARGES	15,718.52	TOTAL MEDICAID LIAB	96,769.69
		LESS: COB	90.45
		LESS: COPAYMENT	1,779.00
		REIMBURSEMENT	94,900.24

TOTAL NUMBER OF CLAIMS 1,944

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,200.60	129.48
MED/SURG SUPPLY	27,852.25	447.75
LABORATORY-GENERAL	83,222.25	11,699.25
RADIOLOGY-DIAGNOSTIC	39,646.00	737.50
CT SCAN	15,340.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,097.00	131.75
IV THERAPY	2,270.75	0.00
OPERATING ROOM	4,279.12	0.00
LABOR/DELIVERY ROOM	0.00	451.50
RESPIRATORY SERVICES	2,489.00	0.00
ANESTHESIA	633.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	240,264.00	0.00
RECOVERY ROOM	1,177.05	0.00
LABORATORY PATHOLOGIC	1,155.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	125.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,819.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,609.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,277.65	0.00
OTHER LAB SERVICES	798.50	2,038.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	133.50	0.00
MRI SERVICES	1,718.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,231.12	82.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	476,339.31	15,718.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	476,339.31	15,718.52

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,174.53	ADJUSTMENTS	0.00
COVERED CHARGES	9,946.28	CONTRACTUAL ALLOW	3,206.12
NON-COVERED CHARGES	1,228.25	TOTAL MEDICAID LIAB	6,740.16
		LESS: COB	6,728.16
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	600.38	0.00
MED/SURG SUPPLY	336.25	0.00
LABORATORY-GENERAL	2,672.50	678.25
RADIOLOGY-DIAGNOSTIC	147.50	304.50
CT SCAN	1,618.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	263.50	0.00
IV THERAPY	156.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,369.25	245.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	711.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	352.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	718.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,946.28	1,228.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,946.28	1,228.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,510,054.22	ADJUSTMENTS	3,964.94
COVERED CHARGES	3,249,106.93	CONTRACTUAL ALLOW	2,416,479.30
NON-COVERED CHARGES	260,947.29	TOTAL MEDICAID LIAB	832,627.63
		LESS: COB	0.00
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	832,123.63

TOTAL NUMBER OF CLAIMS 210

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,049.25	3,297.16
MED/SURG SUPPLY	778,128.00	217.00
LABORATORY-GENERAL	0.00	108.25
RADIOLOGY-DIAGNOSTIC	18,560.75	1,227.50
CT SCAN	26,486.00	5,501.75
PHYSICAL THERAPY	2,433.50	2,348.25
EKG/ECG	4,949.00	0.00
IV THERAPY	13,448.25	0.00
OPERATING ROOM	426,484.83	7,779.09
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,993.50	150.75
ANESTHESIA	44,326.36	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,644.50	0.00
RECOVERY ROOM	69,237.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	459,601.10	7,664.35
OCCUPATIONAL THERAPY	168.50	0.00
SPEECH PATHOLOGY	144.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,268.00	265.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,750.00	0.00
BLOOD	180.75	0.00
BLOOD STORAGE & PRO.	45,752.75	16,764.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,588.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	52,390.00	1,836.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,171.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	47,618.48	642.60
OTHER LAB SERVICES	8,088.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	9,363.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	216,496.48	32,735.22
MRI SERVICES	23,504.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	61.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	610,643.68	170,984.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,249,106.93	260,947.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,249,106.93	260,947.29

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,749.71	ADJUSTMENTS	0.00
COVERED CHARGES	9,555.21	CONTRACTUAL ALLOW	3,886.31
NON-COVERED CHARGES	194.50	TOTAL MEDICAID LIAB	5,668.90
		LESS: COB	5,668.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173.96	0.00
MED/SURG SUPPLY	156.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	546.75	0.00
CT SCAN	6,181.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,480.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	180.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	835.75	194.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,555.21	194.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,555.21	194.50

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	27,301,128.46	ADJUSTMENTS	384,330.35
COVERED CHARGES	26,387,114.37	CONTRACTUAL ALLOW	14,883,105.55
NON-COVERED CHARGES	914,014.09	TOTAL MEDICAID LIAB	11,504,008.82
		LESS: COB	36,214.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,467,793.87

TOTAL NUMBER OF ADMISSIONS 3,359

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7,652	0	2,671,988.00	563,645.00
NURSERY CARE CHARGES	2,262	0	757,590.00	99,825.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9,914	0	3,429,578.00	663,470.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	650	0	659,170.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	650	0	659,170.00	0.00
TOTAL ACCOMODATIONS	10,564	0	4,088,748.00	663,470.00

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,735,009.62	1,385.25
MED/SURG SUPPLY	4,080,389.30	4,253.75
LABORATORY-GENERAL	3,536,680.14	0.00
RADIOLOGY-DIAGNOSTIC	565,572.00	0.00
CT SCAN	789,111.25	0.00
PHYSICAL THERAPY	126,973.50	0.00
EKG/ECG	585,396.38	0.00
IV THERAPY	76,356.25	0.00
OPERATING ROOM	1,448,348.23	0.00
LABOR/DELIVERY ROOM	720,746.50	0.00
RESPIRATORY SERVICES	923,149.75	0.00
ANESTHESIA	253,736.68	0.00
GI SERVICES	46,017.17	0.00
EMERGENCY ROOM	340,577.00	0.00
RECOVERY ROOM	305,135.92	0.00
LABORATORY PATHOLOGIC	229,803.15	0.00
RADIOLOGY THERAPEUTIC	53,250.50	0.00
OCCUPATIONAL THERAPY	14,542.00	0.00
SPEECH PATHOLOGY	16,467.00	0.00
RENAL DIALYSIS	13,599.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17,859.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	189,610.75	3,945.50
BLOOD	3,348.47	0.00
BLOOD STORAGE & PRO.	494,519.75	210,817.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	79,809.50	0.00
AUDIOLOGY	57,944.50	0.00
CARDIOLOGY	390,057.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,657.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	574,285.76	468.00
OTHER LAB SERVICES	101,854.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,522.75	0.00
OTHER THERAPEUTIC SERVI	0.00	951.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	143,125.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	2,532.25	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	624.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,365,236.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	82.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10,158.09

TOTAL ANCILLARY	22,298,366.37	250,544.09
TOTAL ACCOMODATIONS	4,088,748.00	663,470.00
TOTAL CHARGES	26,387,114.37	914,014.09

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	634,643.12	ADJUSTMENTS	0.00
COVERED CHARGES	610,257.12	CONTRACTUAL ALLOW	63,359.11
NON-COVERED CHARGES	24,386.00	TOTAL MEDICAID LIAB	546,898.01
		LESS: COB	546,898.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 110

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	212	1	73,680.00	20,455.00
NURSERY CARE CHARGES	55	0	18,060.00	1,860.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	267	1	91,740.00	22,315.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	2	0	2,040.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	2,040.00	0.00
TOTAL ACCOMODATIONS	269	1	93,780.00	22,315.00

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115,633.16	140.00
MED/SURG SUPPLY	72,280.91	0.00
LABORATORY-GENERAL	86,163.75	0.00
RADIOLOGY-DIAGNOSTIC	8,021.61	0.00
CT SCAN	7,797.50	0.00
PHYSICAL THERAPY	279.50	0.00
EKG/ECG	21,613.75	0.00
IV THERAPY	740.00	0.00
OPERATING ROOM	41,852.33	0.00
LABOR/DELIVERY ROOM	53,543.25	0.00
RESPIRATORY SERVICES	4,092.25	0.00
ANESTHESIA	7,220.06	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,802.00	0.00
RECOVERY ROOM	9,260.08	0.00
LABORATORY PATHOLOGIC	6,264.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	155.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,674.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,699.00	1,931.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,576.50	0.00
CARDIOLOGY	5,501.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	400.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,549.03	0.00
OTHER LAB SERVICES	797.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.75	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,158.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,370.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	516,477.12	2,071.00
TOTAL ACCOMODATIONS	93,780.00	22,315.00
TOTAL CHARGES	610,257.12	24,386.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,242,826.93	ADJUSTMENTS	297,293.87
COVERED CHARGES	16,613,426.15	CONTRACTUAL ALLOW	10,956,842.00
NON-COVERED CHARGES	1,629,400.78	TOTAL MEDICAID LIAB	5,656,584.15
		LESS: COB	10,986.91
		LESS: COPAYMENT	12,720.00
		REIMBURSEMENT	5,632,877.24
		ALL OTHER	5,018,330.24
		FEE SCHEDULE-LAB	563,347.56
		INJECTABLE DRUGS	51,199.44

TOTAL NUMBER OF CLAIMS 19,327

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,173,595.25	42,035.55
MED/SURG SUPPLY	1,335,567.76	34,369.50
LABORATORY-GENERAL	320.50	131,483.25
RADIOLOGY-DIAGNOSTIC	850,729.50	29,490.25
CT SCAN	1,225,283.50	18,852.00
PHYSICAL THERAPY	114,344.00	8,580.25
EKG/ECG	502,329.75	1,464.75
IV THERAPY	182,258.75	0.00
OPERATING ROOM	918,548.82	23,821.51
LABOR/DELIVERY ROOM	4,802.75	1,560.50
RESPIRATORY SERVICES	172,895.55	0.00
ANESTHESIA	138,378.41	2,240.40
GI SERVICES	60,415.95	0.00
EMERGENCY ROOM	1,872,734.00	851.00
RECOVERY ROOM	293,838.30	2,497.57
LABORATORY PATHOLOGIC	0.00	399.75
RADIOLOGY THERAPEUTIC	148,365.70	4,344.10
OCCUPATIONAL THERAPY	6,543.75	2,141.50
SPEECH PATHOLOGY	11,150.25	187.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	86,625.00	267.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	387,209.50	15,203.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	148,120.50	47,686.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	198,419.25	0.00
AUDIOLOGY	4,511.00	0.00
CARDIOLOGY	261,709.50	13,896.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	103,569.50	390.25
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	940,633.13	3,562.47
OTHER LAB SERVICES	470,660.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,672.50	0.00
OTHER THERAPEUTIC SERVI	0.00	9,086.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,961,927.72	672,740.60
MRI SERVICES	893,122.50	4,158.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	210.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	10,726.75	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	132,416.31	556,113.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	877.75

TOTAL ANCILLARY	16,613,426.15	1,628,510.78
TOTAL ACCOMODATIONS	0.00	890.00
TOTAL CHARGES	16,613,426.15	1,629,400.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	404,630.35	ADJUSTMENTS	0.00
COVERED CHARGES	300,461.17	CONTRACTUAL ALLOW	22,379.28
NON-COVERED CHARGES	104,169.18	TOTAL MEDICAID LIAB	278,081.89
		LESS: COB	277,877.89
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	0.00
		ALL OTHER	10,184.24-
		FEE SCHEDULE-LAB	9,500.10
		INJECTABLE DRUGS	684.14

TOTAL NUMBER OF CLAIMS 391

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,410.51	835.49
MED/SURG SUPPLY	21,967.72	1,072.25
LABORATORY-GENERAL	0.00	3,142.25
RADIOLOGY-DIAGNOSTIC	13,114.25	0.00
CT SCAN	18,666.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	13,979.75	0.00
IV THERAPY	1,764.50	0.00
OPERATING ROOM	15,663.42	1,459.22
LABOR/DELIVERY ROOM	436.50	0.00
RESPIRATORY SERVICES	2,196.25	86.25
ANESTHESIA	2,565.56	154.01
GI SERVICES	1,998.77	0.00
EMERGENCY ROOM	18,845.50	0.00
RECOVERY ROOM	5,395.15	413.38
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,957.75	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	930.25	65.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,484.00	7,794.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,238.50	1,346.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,033.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,897.50	5,322.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,182.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,996.28	0.00
OTHER LAB SERVICES	14,099.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	394.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,531.68	6,703.25
MRI SERVICES	14,192.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,914.08	75,379.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	300,461.17	104,169.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	300,461.17	104,169.18

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	896,437.15	ADJUSTMENTS	4,134.00
COVERED CHARGES	879,138.23	CONTRACTUAL ALLOW	755,329.93
NON-COVERED CHARGES	17,298.92	TOTAL MEDICAID LIAB	123,808.30
		LESS: COB	224.72
		LESS: COPAYMENT	2,316.00
		REIMBURSEMENT	121,267.58

TOTAL NUMBER OF CLAIMS 2,492

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,557.28	18.00
MED/SURG SUPPLY	27,740.00	1,376.00
LABORATORY-GENERAL	177,208.00	13,253.25
RADIOLOGY-DIAGNOSTIC	57,337.25	390.00
CT SCAN	27,347.25	909.25
PHYSICAL THERAPY	2,593.00	0.00
EKG/ECG	13,548.00	0.00
IV THERAPY	8,294.75	0.00
OPERATING ROOM	3,613.54	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,117.25	0.00
ANESTHESIA	451.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	442,761.45	166.50
RECOVERY ROOM	1,117.20	0.00
LABORATORY PATHOLOGIC	584.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	489.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,148.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,306.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,363.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	390.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,452.75	0.00
OTHER LAB SERVICES	853.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	349.50	116.50
MRI SERVICES	12,748.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,766.74	1,069.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	879,138.23	17,298.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	879,138.23	17,298.92

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	11,063.96	ADJUSTMENTS	0.00
COVERED CHARGES	10,453.96	CONTRACTUAL ALLOW	3,527.26
NON-COVERED CHARGES	610.00	TOTAL MEDICAID LIAB	6,926.70
		LESS: COB	6,908.70
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	507.22	0.00
MED/SURG SUPPLY	337.25	143.00
LABORATORY-GENERAL	2,232.50	210.25
RADIOLOGY-DIAGNOSTIC	1,358.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	142.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	366.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,991.75	140.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	391.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	47.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	116.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,453.96	610.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,453.96	610.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,174,619.68	ADJUSTMENTS	38,985.45
COVERED CHARGES	4,608,544.30	CONTRACTUAL ALLOW	3,684,364.08
NON-COVERED CHARGES	566,075.38	TOTAL MEDICAID LIAB	924,180.22
		LESS: COB	3,155.19
		LESS: COPAYMENT	1,449.00
		REIMBURSEMENT	919,576.03

TOTAL NUMBER OF CLAIMS 240

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	507,773.52	9,746.56
MED/SURG SUPPLY	847,656.99	1,300.00
LABORATORY-GENERAL	0.00	391.50
RADIOLOGY-DIAGNOSTIC	28,476.00	4,074.00
CT SCAN	50,192.25	0.00
PHYSICAL THERAPY	2,330.75	1,132.75
EKG/ECG	5,806.50	0.00
IV THERAPY	34,313.80	0.00
OPERATING ROOM	483,214.10	3,184.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,441.00	0.00
ANESTHESIA	50,761.84	1,332.12
GI SERVICES	1,379.20	0.00
EMERGENCY ROOM	23,805.75	0.00
RECOVERY ROOM	76,869.90	0.00
LABORATORY PATHOLOGIC	0.00	281.00
RADIOLOGY THERAPEUTIC	704,557.05	3,817.10
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	204.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,326.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,469.25	3,945.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	72,546.25	26,542.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,983.00	0.00
AUDIOLOGY	625.25	0.00
CARDIOLOGY	51,011.50	1,972.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,149.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	47,108.76	2,921.31
OTHER LAB SERVICES	25,372.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	12,933.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,485,307.71	169,575.48
MRI SERVICES	50,170.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,690.68	322,549.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	375.66

TOTAL ANCILLARY	4,608,544.30	566,075.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,608,544.30	566,075.38

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	142,335.06	ADJUSTMENTS	0.00
COVERED CHARGES	70,202.31	CONTRACTUAL ALLOW	8,697.19-
NON-COVERED CHARGES	72,132.75	TOTAL MEDICAID LIAB	78,899.50
		LESS: COB	78,866.50
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,887.31	0.00
MED/SURG SUPPLY	520.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,062.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	17,558.25	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	460.25	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	541.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,626.50	800.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	87.25	70,791.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,202.31	72,132.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,202.31	72,132.75

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	26,547,566.85	ADJUSTMENTS	389,420.00
COVERED CHARGES	26,149,016.04	CONTRACTUAL ALLOW	15,213,355.87
NON-COVERED CHARGES	398,550.81	TOTAL MEDICAID LIAB	10,935,660.17
		LESS: COB	40,434.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,895,226.00

TOTAL NUMBER OF ADMISSIONS 3,572

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7,447	7	3,016,260.00	190,005.00
NURSERY CARE CHARGES	2,491	0	881,955.00	68,085.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9,938	7	3,898,215.00	258,090.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	341	0	347,820.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	341	0	347,820.00	0.00
TOTAL ACCOMODATIONS	10,279	7	4,246,035.00	258,090.00

INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,380,398.79	1,275.80
MED/SURG SUPPLY	4,808,066.20	5,509.50
LABORATORY-GENERAL	3,282,209.57	0.00
RADIOLOGY-DIAGNOSTIC	511,447.50	0.00
CT SCAN	707,427.84	0.00
PHYSICAL THERAPY	93,854.25	0.00
EKG/ECG	584,163.50	0.00
IV THERAPY	97,785.00	0.00
OPERATING ROOM	1,481,474.36	0.00
LABOR/DELIVERY ROOM	841,299.95	0.00
RESPIRATORY SERVICES	654,372.35	0.00
ANESTHESIA	274,539.69	0.00
GI SERVICES	34,073.35	0.00
EMERGENCY ROOM	305,882.00	0.00
RECOVERY ROOM	343,206.44	0.00
LABORATORY PATHOLOGIC	222,132.50	0.00
RADIOLOGY THERAPEUTIC	34,161.00	0.00
OCCUPATIONAL THERAPY	9,780.75	0.00
SPEECH PATHOLOGY	10,870.00	0.00
RENAL DIALYSIS	6,308.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,132.00	4,251.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	180,709.00	0.00
BLOOD	3,315.73	0.00
BLOOD STORAGE & PRO.	363,794.17	119,234.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	60,696.75	0.00
AUDIOLOGY	65,589.00	0.00
CARDIOLOGY	345,127.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,523.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	505,020.48	1,818.50
OTHER LAB SERVICES	110,850.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,161.75	0.00
OTHER THERAPEUTIC SERVI	0.00	1,658.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	134,966.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	484.25
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,000.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,429,641.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,228.51

TOTAL ANCILLARY	21,902,981.04	140,460.81
TOTAL ACCOMODATIONS	4,246,035.00	258,090.00
TOTAL CHARGES	26,149,016.04	398,550.81

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	409,437.18	ADJUSTMENTS	0.00
COVERED CHARGES	399,891.43	CONTRACTUAL ALLOW	57,050.95
NON-COVERED CHARGES	9,545.75	TOTAL MEDICAID LIAB	342,840.48
		LESS: COB	342,840.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	129	0	52,245.00	5,105.00
NURSERY CARE CHARGES	31	0	11,430.00	1,360.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	160	0	63,675.00	6,465.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	160	0	63,675.00	6,465.00

ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,074.34	0.00
MED/SURG SUPPLY	53,116.00	0.00
LABORATORY-GENERAL	49,016.75	0.00
RADIOLOGY-DIAGNOSTIC	6,487.75	0.00
CT SCAN	6,606.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,584.50	0.00
IV THERAPY	1,249.00	0.00
OPERATING ROOM	24,980.76	0.00
LABOR/DELIVERY ROOM	28,024.00	0.00
RESPIRATORY SERVICES	15,585.75	0.00
ANESTHESIA	4,850.52	0.00
GI SERVICES	1,382.67	0.00
EMERGENCY ROOM	2,607.50	0.00
RECOVERY ROOM	7,468.79	0.00
LABORATORY PATHOLOGIC	3,567.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,586.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,821.25	2,968.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,670.00	0.00
AUDIOLOGY	897.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,609.85	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.75	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,000.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	112.25

TOTAL ANCILLARY	336,216.43	3,080.75
TOTAL ACCOMODATIONS	63,675.00	6,465.00
TOTAL CHARGES	399,891.43	9,545.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	18,606,482.93	ADJUSTMENTS	102,269.96
COVERED CHARGES	17,366,545.54	CONTRACTUAL ALLOW	12,729,757.76
NON-COVERED CHARGES	1,239,937.39	TOTAL MEDICAID LIAB	4,636,787.78
		LESS: COB	4,585.44
		LESS: COPAYMENT	14,418.00
		REIMBURSEMENT	4,617,784.34
		ALL OTHER	3,905,281.87
		FEE SCHEDULE-LAB	661,271.27
		INJECTABLE DRUGS	51,231.20

TOTAL NUMBER OF CLAIMS 18,645

OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,213,636.62	3,075.58
MED/SURG SUPPLY	1,475,401.70	39,584.75
LABORATORY-GENERAL	0.00	142,727.00
RADIOLOGY-DIAGNOSTIC	876,391.50	57,009.00
CT SCAN	1,217,767.47	63,205.00
PHYSICAL THERAPY	104,314.50	7,802.50
EKG/ECG	526,963.20	703.50
IV THERAPY	353,868.75	6,037.00
OPERATING ROOM	934,722.61	95,089.04
LABOR/DELIVERY ROOM	8,206.50	0.00
RESPIRATORY SERVICES	196,085.00	453.75
ANESTHESIA	146,468.34	0.00
GI SERVICES	46,459.81	0.00
EMERGENCY ROOM	1,780,510.75	7,213.75
RECOVERY ROOM	316,729.64	1,908.30
LABORATORY PATHOLOGIC	0.00	1,004.50
RADIOLOGY THERAPEUTIC	164,091.00	34,047.25
OCCUPATIONAL THERAPY	17,406.50	2,257.25
SPEECH PATHOLOGY	6,625.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	68,037.75	3,441.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	465,490.75	12,552.75
BLOOD	195.75	0.00
BLOOD STORAGE & PRO.	115,723.00	27,994.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	189,055.00	1,880.75
AUDIOLOGY	7,282.25	0.00
CARDIOLOGY	349,240.00	45,019.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	90,358.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	843,406.33	1,210.50
OTHER LAB SERVICES	563,258.00	536.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,389.50	792.50
OTHER THERAPEUTIC SERVI	0.00	6,680.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,266,720.86	458,527.06
MRI SERVICES	846,279.50	55,690.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	147.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,223.25	0.00
FREE STANDING CLINIC	0.00	85.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	168,236.71	159,301.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,815.83

TOTAL ANCILLARY	17,366,545.54	1,237,792.39
TOTAL ACCOMODATIONS	0.00	2,145.00
TOTAL CHARGES	17,366,545.54	1,239,937.39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	342,134.33	ADJUSTMENTS	0.00
COVERED CHARGES	320,801.58	CONTRACTUAL ALLOW	71,217.16
NON-COVERED CHARGES	21,332.75	TOTAL MEDICAID LIAB	249,584.42
		LESS: COB	249,347.42
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	0.00
		ALL OTHER	12,593.89-
		FEE SCHEDULE-LAB	11,914.55
		INJECTABLE DRUGS	679.34

TOTAL NUMBER OF CLAIMS 425

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,841.56	0.00
MED/SURG SUPPLY	25,535.00	298.75
LABORATORY-GENERAL	0.00	4,003.25
RADIOLOGY-DIAGNOSTIC	13,719.50	1,242.00
CT SCAN	15,975.00	1,554.25
PHYSICAL THERAPY	5,190.00	0.00
EKG/ECG	15,369.00	0.00
IV THERAPY	6,418.00	525.00
OPERATING ROOM	24,643.27	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,376.00	0.00
ANESTHESIA	3,668.89	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,032.75	0.00
RECOVERY ROOM	8,749.93	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,792.50	0.00
OCCUPATIONAL THERAPY	2,121.25	0.00
SPEECH PATHOLOGY	672.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	485.50	167.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,716.75	4,389.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,419.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,033.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,968.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,353.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,529.71	0.00
OTHER LAB SERVICES	15,753.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	92.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	77,279.42	7,769.50
MRI SERVICES	9,832.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,234.80	1,383.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	320,801.58	21,332.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320,801.58	21,332.75

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,066,028.76	ADJUSTMENTS	3,082.52
COVERED CHARGES	1,038,015.01	CONTRACTUAL ALLOW	911,377.41
NON-COVERED CHARGES	28,013.75	TOTAL MEDICAID LIAB	126,637.60
		LESS: COB	296.04
		LESS: COPAYMENT	2,583.00
		REIMBURSEMENT	123,758.56

TOTAL NUMBER OF CLAIMS 2,529

OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,981.93	0.00
MED/SURG SUPPLY	28,599.72	1,935.75
LABORATORY-GENERAL	239,700.00	13,824.00
RADIOLOGY-DIAGNOSTIC	69,533.75	2,924.75
CT SCAN	51,241.00	898.00
PHYSICAL THERAPY	147.25	168.00
EKG/ECG	8,664.75	0.00
IV THERAPY	20,598.00	398.00
OPERATING ROOM	4,409.20	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27,634.75	0.00
ANESTHESIA	425.19	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	468,638.50	283.00
RECOVERY ROOM	1,098.80	0.00
LABORATORY PATHOLOGIC	33.75	0.00
RADIOLOGY THERAPEUTIC	8,541.50	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	280.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,185.25	419.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,126.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,997.39	0.00
OTHER LAB SERVICES	3,071.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	97.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,013.78	134.50
MRI SERVICES	1,855.50	4,880.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	90.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28,237.50	1,961.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,038,015.01	28,013.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,038,015.01	28,013.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	50,827.33	ADJUSTMENTS	0.00
COVERED CHARGES	49,885.08	CONTRACTUAL ALLOW	35,775.61
NON-COVERED CHARGES	942.25	TOTAL MEDICAID LIAB	14,109.47
		LESS: COB	14,040.47
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	755.91	0.00
MED/SURG SUPPLY	637.00	0.00
LABORATORY-GENERAL	5,049.50	40.50
RADIOLOGY-DIAGNOSTIC	2,511.75	0.00
CT SCAN	4,733.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	350.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	301.75	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,223.00	169.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	28,535.75	604.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	98.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	148.99	128.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	539.93	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	49,885.08	942.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,885.08	942.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,072,221.73	ADJUSTMENTS	0.00
COVERED CHARGES	4,513,424.75	CONTRACTUAL ALLOW	3,712,327.52
NON-COVERED CHARGES	558,796.98	TOTAL MEDICAID LIAB	801,097.23
		LESS: COB	0.00
		LESS: COPAYMENT	2,751.00
		REIMBURSEMENT	798,346.23

TOTAL NUMBER OF CLAIMS 237

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317,163.78	426.60
MED/SURG SUPPLY	1,076,155.67	1,495.25
LABORATORY-GENERAL	0.00	157.75
RADIOLOGY-DIAGNOSTIC	26,038.25	3,618.50
CT SCAN	25,154.75	11,004.00
PHYSICAL THERAPY	3,375.00	1,187.50
EKG/ECG	5,295.00	285.00
IV THERAPY	28,767.00	200.00
OPERATING ROOM	467,352.87	60,099.83
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,394.50	88.50
ANESTHESIA	57,958.05	3,835.22
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,146.00	0.00
RECOVERY ROOM	91,121.15	0.00
LABORATORY PATHOLOGIC	0.00	297.25
RADIOLOGY THERAPEUTIC	440,641.75	62,563.25
OCCUPATIONAL THERAPY	589.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,365.00	1,862.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,200.25	195.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,350.11	4,153.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,787.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,912.50	12,337.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	457.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	43,146.39	0.00
OTHER LAB SERVICES	5,882.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.75	0.00
OTHER THERAPEUTIC SERVI	0.00	9,900.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,795,545.79	166,842.73
MRI SERVICES	6,714.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	200.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,680.44	218,123.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	122.67

TOTAL ANCILLARY	4,513,424.75	558,796.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,513,424.75	558,796.98

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
TITLE XVIII NO: HOSP29

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,629.98	ADJUSTMENTS	0.00
COVERED CHARGES	11,629.98	CONTRACTUAL ALLOW	1,826.76
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	9,803.22
		LESS: COB	9,797.22
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 EAST 18TH ST
TIFTON GA 31794-3648

PROVIDER NUMBER 000001922A
NUMBER OF BEDS 168
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP29

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,452.35	0.00
MED/SURG SUPPLY	3,316.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,676.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,755.22	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	88.50	0.00
ANESTHESIA	411.96	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,529.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	399.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,629.98	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,629.98	0.00

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,206,514.55	ADJUSTMENTS	16,207.74
COVERED CHARGES	1,194,223.70	CONTRACTUAL ALLOW	189,065.11
NON-COVERED CHARGES	12,290.85	TOTAL MEDICAID LIAB	1,005,158.59
		LESS: COB	21,135.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	984,022.75

TOTAL NUMBER OF ADMISSIONS 396

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	653	0	211,915.00	7,670.00
NURSERY CARE CHARGES	258	0	45,150.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	911	0	257,065.00	7,670.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	25	0	13,750.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	25	0	13,750.00	0.00
TOTAL ACCOMODATIONS	936	0	270,815.00	7,670.00

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231,971.50	0.00
MED/SURG SUPPLY	125,342.70	20.75
LABORATORY-GENERAL	126,719.20	1,538.00
RADIOLOGY-DIAGNOSTIC	26,110.00	0.00
CT SCAN	73,800.00	0.00
PHYSICAL THERAPY	5,925.00	0.00
EKG/ECG	3,234.00	0.00
IV THERAPY	8,775.00	0.00
OPERATING ROOM	82,764.00	0.00
LABOR/DELIVERY ROOM	91,157.00	0.00
RESPIRATORY SERVICES	43,275.00	0.00
ANESTHESIA	1,350.00	0.00
GI SERVICES	2,900.00	0.00
EMERGENCY ROOM	10,404.00	0.00
RECOVERY ROOM	8,470.00	0.00
LABORATORY PATHOLOGIC	6,453.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,760.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	400.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,300.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,123.00	250.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,675.00	0.00
AUDIOLOGY	4,440.00	0.00
CARDIOLOGY	3,173.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,100.00	0.00
OTHER LAB SERVICES	1,850.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,638.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	638.60
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,037.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	135.00

TOTAL ANCILLARY	923,408.70	4,620.85
TOTAL ACCOMODATIONS	270,815.00	7,670.00
TOTAL CHARGES	1,194,223.70	12,290.85

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	24,228.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,663.00	CONTRACTUAL ALLOW	1,006.33
NON-COVERED CHARGES	565.00	TOTAL MEDICAID LIAB	22,656.67
		LESS: COB	22,656.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	12	0	3,900.00	50.00
NURSERY CARE CHARGES	3	0	525.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	4,425.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	4,425.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,029.50	0.00
MED/SURG SUPPLY	2,638.50	0.00
LABORATORY-GENERAL	3,363.00	0.00
RADIOLOGY-DIAGNOSTIC	350.00	0.00
CT SCAN	4,875.00	0.00
PHYSICAL THERAPY	660.00	0.00
EKG/ECG	77.00	0.00
IV THERAPY	225.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	305.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	425.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	80.00	0.00
CARDIOLOGY	560.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	500.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	515.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,238.00	515.00
TOTAL ACCOMODATIONS	4,425.00	50.00
TOTAL CHARGES	23,663.00	565.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,624,196.67	ADJUSTMENTS	15,965.64
COVERED CHARGES	1,504,063.92	CONTRACTUAL ALLOW	880,284.93
NON-COVERED CHARGES	120,132.75	TOTAL MEDICAID LIAB	623,778.99
		LESS: COB	1,765.72
		LESS: COPAYMENT	2,463.00
		REIMBURSEMENT	619,550.27
		ALL OTHER	556,347.49
		FEE SCHEDULE-LAB	57,642.01
		INJECTABLE DRUGS	5,560.77

TOTAL NUMBER OF CLAIMS 3,695

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,287.25	10,350.25
MED/SURG SUPPLY	75,220.37	691.25
LABORATORY-GENERAL	0.00	10,624.00
RADIOLOGY-DIAGNOSTIC	115,140.00	8,765.00
CT SCAN	202,850.00	1,200.00
PHYSICAL THERAPY	25,060.00	2,125.00
EKG/ECG	9,072.00	0.00
IV THERAPY	29,475.00	0.00
OPERATING ROOM	98,961.00	12,684.00
LABOR/DELIVERY ROOM	12,155.00	0.00
RESPIRATORY SERVICES	8,881.00	112.00
ANESTHESIA	360.00	0.00
GI SERVICES	18,622.00	3,832.00
EMERGENCY ROOM	153,028.75	1,539.00
RECOVERY ROOM	19,187.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	450.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	8,690.00	750.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,692.00	295.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	167,640.00	8,750.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,012.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	40,725.00	300.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,275.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,300.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,910.00	0.00
OTHER LAB SERVICES	12,250.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	750.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	263,067.05	45,990.25
MRI SERVICES	86,700.00	8,925.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,053.00	2,330.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	120.00

TOTAL ANCILLARY	1,504,063.92	120,132.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,504,063.92	120,132.75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,685.85	ADJUSTMENTS	0.00
COVERED CHARGES	12,074.85	CONTRACTUAL ALLOW	5,457.59
NON-COVERED CHARGES	611.00	TOTAL MEDICAID LIAB	6,617.26
		LESS: COB	6,605.26
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	644.36-
		FEE SCHEDULE-LAB	644.36
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	463.00	0.00
MED/SURG SUPPLY	371.25	0.00
LABORATORY-GENERAL	0.00	144.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00
CT SCAN	1,400.00	0.00
PHYSICAL THERAPY	1,350.00	0.00
EKG/ECG	77.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,182.00	0.00
LABOR/DELIVERY ROOM	768.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,065.00	0.00
RECOVERY ROOM	75.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,000.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	61.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	600.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,387.60	292.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	175.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,074.85	611.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,074.85	611.00

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	104,356.00	ADJUSTMENTS	644.00
COVERED CHARGES	101,572.00	CONTRACTUAL ALLOW	76,588.16
NON-COVERED CHARGES	2,784.00	TOTAL MEDICAID LIAB	24,983.84
		LESS: COB	67.57
		LESS: COPAYMENT	249.00
		REIMBURSEMENT	24,667.27

TOTAL NUMBER OF CLAIMS 508

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,122.75	136.00
MED/SURG SUPPLY	1,027.25	155.00
LABORATORY-GENERAL	15,739.00	1,608.00
RADIOLOGY-DIAGNOSTIC	7,845.00	260.00
CT SCAN	9,475.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	385.00	0.00
IV THERAPY	1,575.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	448.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	53,160.00	50.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	50.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,875.00	400.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	825.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	175.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	101,572.00	2,784.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	101,572.00	2,784.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,406.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,333.00	CONTRACTUAL ALLOW	1,859.90
NON-COVERED CHARGES	73.00	TOTAL MEDICAID LIAB	473.10
		LESS: COB	470.10
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	352.00	73.00
RADIOLOGY-DIAGNOSTIC	125.00	0.00
CT SCAN	975.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	785.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,333.00	73.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,333.00	73.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,097,246.66	ADJUSTMENTS	12,136.09
COVERED CHARGES	1,080,472.91	CONTRACTUAL ALLOW	211,475.86
NON-COVERED CHARGES	16,773.75	TOTAL MEDICAID LIAB	868,997.05
		LESS: COB	18,628.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	850,368.27

TOTAL NUMBER OF ADMISSIONS 372

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	563	0	182,522.50	7,505.00
NURSERY CARE CHARGES	244	0	42,700.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	807	0	225,222.50	7,505.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	26	0	14,300.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	26	0	14,300.00	0.00
TOTAL ACCOMODATIONS	833	0	239,522.50	7,505.00

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,614.15	0.00
MED/SURG SUPPLY	110,418.71	20.75
LABORATORY-GENERAL	124,634.60	991.00
RADIOLOGY-DIAGNOSTIC	20,520.00	0.00
CT SCAN	46,375.00	0.00
PHYSICAL THERAPY	2,650.00	0.00
EKG/ECG	3,542.00	0.00
IV THERAPY	8,325.00	0.00
OPERATING ROOM	65,952.00	0.00
LABOR/DELIVERY ROOM	90,235.50	0.00
RESPIRATORY SERVICES	46,545.00	0.00
ANESTHESIA	1,110.00	0.00
GI SERVICES	5,100.00	0.00
EMERGENCY ROOM	13,100.00	0.00
RECOVERY ROOM	7,052.50	0.00
LABORATORY PATHOLOGIC	7,326.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,160.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	150.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,510.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,226.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,150.00	0.00
AUDIOLOGY	1,640.00	0.00
CARDIOLOGY	4,292.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,625.00	3,400.00
OTHER LAB SERVICES	2,100.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,950.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,796.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,707.00

TOTAL ANCILLARY	840,950.41	9,268.75
TOTAL ACCOMODATIONS	239,522.50	7,505.00
TOTAL CHARGES	1,080,472.91	16,773.75

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,644.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,669.00	CONTRACTUAL ALLOW	120.27
NON-COVERED CHARGES	975.00	TOTAL MEDICAID LIAB	5,548.73
		LESS: COB	5,548.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	975.00	75.00
NURSERY CARE CHARGES	5	0	875.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	1,850.00	75.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	1,850.00	75.00

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	539.50	0.00
MED/SURG SUPPLY	468.25	0.00
LABORATORY-GENERAL	886.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	905.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	952.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	40.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	900.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,819.00	900.00
TOTAL ACCOMODATIONS	1,850.00	75.00
TOTAL CHARGES	5,669.00	975.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,836,270.94	ADJUSTMENTS	1,298.84
COVERED CHARGES	1,682,790.03	CONTRACTUAL ALLOW	1,091,903.25
NON-COVERED CHARGES	153,480.91	TOTAL MEDICAID LIAB	590,886.78
		LESS: COB	1,855.97
		LESS: COPAYMENT	2,475.00
		REIMBURSEMENT	586,555.81
		ALL OTHER	524,832.37
		FEE SCHEDULE-LAB	61,723.44
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,648

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,027.75	1,103.75
MED/SURG SUPPLY	101,407.34	826.00
LABORATORY-GENERAL	0.00	5,476.16
RADIOLOGY-DIAGNOSTIC	133,815.00	2,425.00
CT SCAN	217,575.00	6,500.00
PHYSICAL THERAPY	15,645.00	1,065.00
EKG/ECG	10,093.00	0.00
IV THERAPY	28,575.00	2,700.00
OPERATING ROOM	149,595.00	9,738.00
LABOR/DELIVERY ROOM	12,567.50	0.00
RESPIRATORY SERVICES	11,508.00	112.00
ANESTHESIA	840.00	0.00
GI SERVICES	15,407.00	0.00
EMERGENCY ROOM	189,964.00	8,163.00
RECOVERY ROOM	29,382.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,500.00	0.00
OCCUPATIONAL THERAPY	85.00	120.00
SPEECH PATHOLOGY	14,685.00	1,080.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,992.00	2,700.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	139,935.00	1,810.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,019.00	2,708.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,136.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,112.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,600.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,775.00	0.00
OTHER LAB SERVICES	14,600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,800.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	297,023.94	64,879.50
MRI SERVICES	58,925.00	4,700.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	27,174.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,400.00

TOTAL ANCILLARY	1,682,790.03	153,480.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,682,790.03	153,480.91

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,094.95	ADJUSTMENTS	0.00
COVERED CHARGES	11,313.95	CONTRACTUAL ALLOW	5,271.72
NON-COVERED CHARGES	1,781.00	TOTAL MEDICAID LIAB	6,042.23
		LESS: COB	6,018.23
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	551.92-
		FEE SCHEDULE-LAB	551.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	695.00	0.00
MED/SURG SUPPLY	858.35	0.00
LABORATORY-GENERAL	0.00	170.00
RADIOLOGY-DIAGNOSTIC	350.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,350.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	225.00
OPERATING ROOM	882.00	0.00
LABOR/DELIVERY ROOM	137.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	900.00	50.00
RECOVERY ROOM	210.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	240.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25.00	50.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	175.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	129.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,100.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	373.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,018.10	282.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	875.00

TOTAL ANCILLARY	11,313.95	1,781.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,313.95	1,781.00

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	143,186.40	ADJUSTMENTS	50.00
COVERED CHARGES	137,804.65	CONTRACTUAL ALLOW	113,489.96
NON-COVERED CHARGES	5,381.75	TOTAL MEDICAID LIAB	24,314.69
		LESS: COB	52.50
		LESS: COPAYMENT	375.00
		REIMBURSEMENT	23,887.19

TOTAL NUMBER OF CLAIMS 486

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,111.75	0.00
MED/SURG SUPPLY	2,016.00	39.75
LABORATORY-GENERAL	19,796.00	1,642.00
RADIOLOGY-DIAGNOSTIC	9,125.00	0.00
CT SCAN	18,150.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	462.00	0.00
IV THERAPY	5,175.00	225.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	336.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	68,650.00	2,500.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	137.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,200.00	825.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45.00	0.00
MRI SERVICES	1,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	137,804.65	5,381.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,804.65	5,381.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	695.00	ADJUSTMENTS	0.00
COVERED CHARGES	695.00	CONTRACTUAL ALLOW	516.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	179.00
		LESS: COB	179.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	550.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	695.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	695.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,330.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,330.00	CONTRACTUAL ALLOW	3,746.80
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	7,583.20
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	7,577.20

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	100.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,230.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,330.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,330.00	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	936,422.01	ADJUSTMENTS	14,739.34
COVERED CHARGES	918,635.51	CONTRACTUAL ALLOW	344,485.88
NON-COVERED CHARGES	17,786.50	TOTAL MEDICAID LIAB	574,149.63
		LESS: COB	8,555.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	565,594.39

TOTAL NUMBER OF ADMISSIONS 229

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	411	0	132,822.50	7,192.50
NURSERY CARE CHARGES	136	0	23,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	547	0	156,622.50	7,192.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	33	0	18,150.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	33	0	18,150.00	0.00
TOTAL ACCOMODATIONS	580	0	174,772.50	7,192.50

INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	207,646.29	0.00
MED/SURG SUPPLY	77,673.69	0.00
LABORATORY-GENERAL	115,886.00	2,353.00
RADIOLOGY-DIAGNOSTIC	19,835.00	0.00
CT SCAN	61,425.00	0.00
PHYSICAL THERAPY	2,265.00	0.00
EKG/ECG	5,005.00	0.00
IV THERAPY	7,200.00	0.00
OPERATING ROOM	39,606.00	0.00
LABOR/DELIVERY ROOM	47,014.00	0.00
RESPIRATORY SERVICES	31,995.00	0.00
ANESTHESIA	360.00	0.00
GI SERVICES	4,900.00	0.00
EMERGENCY ROOM	11,425.00	0.00
RECOVERY ROOM	3,850.00	0.00
LABORATORY PATHOLOGIC	3,391.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	300.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	200.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,870.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,093.00	250.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,350.00	0.00
AUDIOLOGY	1,280.00	0.00
CARDIOLOGY	20,611.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,950.00	600.00
OTHER LAB SERVICES	7,900.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,100.00	1,025.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,931.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,016.00

TOTAL ANCILLARY	743,863.01	10,594.00
TOTAL ACCOMODATIONS	174,772.50	7,192.50
TOTAL CHARGES	918,635.51	17,786.50

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	7,809.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,759.00	CONTRACTUAL ALLOW	2,463.83
NON-COVERED CHARGES	50.00	TOTAL MEDICAID LIAB	5,295.17
		LESS: COB	5,295.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	650.00	50.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	650.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	650.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,527.25	0.00
MED/SURG SUPPLY	545.75	0.00
LABORATORY-GENERAL	644.00	0.00
RADIOLOGY-DIAGNOSTIC	600.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	225.00	0.00
OPERATING ROOM	2,082.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	425.00	0.00
RECOVERY ROOM	110.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	950.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,109.00	0.00
TOTAL ACCOMODATIONS	650.00	50.00
TOTAL CHARGES	7,759.00	50.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,199,458.49	ADJUSTMENTS	10,255.91
COVERED CHARGES	1,136,205.49	CONTRACTUAL ALLOW	812,926.70
NON-COVERED CHARGES	63,253.00	TOTAL MEDICAID LIAB	323,278.79
		LESS: COB	1,358.42
		LESS: COPAYMENT	1,878.00
		REIMBURSEMENT	320,042.37
		ALL OTHER	279,787.64
		FEE SCHEDULE-LAB	40,254.73
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,058

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,172.50	474.25
MED/SURG SUPPLY	53,455.64	1,622.00
LABORATORY-GENERAL	0.00	2,873.00
RADIOLOGY-DIAGNOSTIC	105,135.00	1,640.00
CT SCAN	146,875.00	7,700.00
PHYSICAL THERAPY	6,060.00	360.00
EKG/ECG	5,392.00	0.00
IV THERAPY	18,360.00	225.00
OPERATING ROOM	96,426.50	0.00
LABOR/DELIVERY ROOM	6,960.00	247.50
RESPIRATORY SERVICES	4,299.00	0.00
ANESTHESIA	390.00	0.00
GI SERVICES	13,813.75	566.75
EMERGENCY ROOM	104,737.00	2,676.00
RECOVERY ROOM	15,370.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,275.00	120.00
SPEECH PATHOLOGY	4,670.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,909.00	621.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	101,800.00	4,370.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	720.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	57,500.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,595.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,900.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,025.00	0.00
OTHER LAB SERVICES	11,300.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,050.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	197,915.10	36,697.25
MRI SERVICES	52,150.00	1,500.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	291.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	219.00

TOTAL ANCILLARY	1,136,205.49	63,253.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,136,205.49	63,253.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	12,007.70	ADJUSTMENTS	0.00
COVERED CHARGES	11,623.70	CONTRACTUAL ALLOW	7,303.35
NON-COVERED CHARGES	384.00	TOTAL MEDICAID LIAB	4,320.35
		LESS: COB	4,299.35
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	849.52-
		FEE SCHEDULE-LAB	849.52
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	821.00	0.00
MED/SURG SUPPLY	332.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	77.00	0.00
IV THERAPY	450.00	0.00
OPERATING ROOM	732.00	0.00
LABOR/DELIVERY ROOM	27.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	30.00	0.00
GI SERVICES	1,140.50	0.00
EMERGENCY ROOM	1,525.00	50.00
RECOVERY ROOM	110.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	50.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	850.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,828.20	234.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	100.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,623.70	384.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,623.70	384.00

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	98,985.85	ADJUSTMENTS	150.00
COVERED CHARGES	95,777.85	CONTRACTUAL ALLOW	82,163.69
NON-COVERED CHARGES	3,208.00	TOTAL MEDICAID LIAB	13,614.16
		LESS: COB	0.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	13,371.16

TOTAL NUMBER OF CLAIMS 271

OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,337.25	0.00
MED/SURG SUPPLY	955.50	0.00
LABORATORY-GENERAL	14,812.10	1,673.00
RADIOLOGY-DIAGNOSTIC	4,925.00	105.00
CT SCAN	17,300.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	385.00	0.00
IV THERAPY	2,025.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	504.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,773.00	1,100.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,200.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	650.00	0.00
OTHER LAB SERVICES	600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	286.00	0.00
MRI SERVICES	3,000.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	180.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	95,777.85	3,208.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	95,777.85	3,208.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE

BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,705.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,699.00	CONTRACTUAL ALLOW	1,042.40
NON-COVERED CHARGES	6.00	TOTAL MEDICAID LIAB	656.60
		LESS: COB	647.60
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: HOSP30

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	239.00	0.00
MED/SURG SUPPLY	39.00	0.00
LABORATORY-GENERAL	121.00	6.00
RADIOLOGY-DIAGNOSTIC	500.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	800.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,699.00	6.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,699.00	6.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION GEN HOSP
214 HOSPITAL CIRCLE
BLAIRSVILLE GA 30512-3102

PROVIDER NUMBER 000001966A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP30

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

****** NO DATA ******

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	53,501,202.19	ADJUSTMENTS	3,014,132.05
COVERED CHARGES	52,693,659.92	CONTRACTUAL ALLOW	33,231,727.32
NON-COVERED CHARGES	807,542.27	TOTAL MEDICAID LIAB	19,461,932.60
		LESS: COB	360,547.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,101,384.99

TOTAL NUMBER OF ADMISSIONS 3,772

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	9,428	14	3,628,800.00	190,965.00
NURSERY CARE CHARGES	3,791	2	1,265,136.50	548,612.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	21	0.00	2,610.00
TOTAL ROUTINE	13,219	37	4,893,936.50	742,187.00
SPECIAL CARE SERVICES				
C C U	331	0	377,980.00	0.00
I C U	2,661	0	2,214,900.00	0.00
N I C U	2,316	0	2,658,240.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,308	0	5,251,120.00	0.00
TOTAL ACCOMODATIONS	18,527	37	10,145,056.50	742,187.00

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,156,329.65	0.00
MED/SURG SUPPLY	9,929,197.14	12,653.56
LABORATORY-GENERAL	4,439,581.93	0.00
RADIOLOGY-DIAGNOSTIC	988,716.00	0.00
CT SCAN	700,442.00	0.00
PHYSICAL THERAPY	233,411.00	0.00
EKG/ECG	146,251.00	0.00
IV THERAPY	343,891.20	0.00
OPERATING ROOM	2,051,042.60	0.00
LABOR/DELIVERY ROOM	1,805,088.10	0.00
RESPIRATORY SERVICES	2,657,352.00	0.00
ANESTHESIA	168,375.00	0.00
GI SERVICES	176,928.00	0.00
EMERGENCY ROOM	889,106.90	0.00
RECOVERY ROOM	270,083.00	0.00
LABORATORY PATHOLOGIC	278,458.00	0.00
RADIOLOGY THERAPEUTIC	5,632.96	0.00
OCCUPATIONAL THERAPY	85,350.00	0.00
SPEECH PATHOLOGY	43,153.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	655.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	454,624.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	295,851.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	108,383.00	0.00
AUDIOLOGY	78,798.00	868.00
CARDIOLOGY	1,538,539.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,281.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	194,421.80	2,816.00
OTHER LAB SERVICES	170,550.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	348.00	100.00
OTHER THERAPEUTIC SERVI	102,290.00	3,456.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	175,382.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	10,610.00
CAST ROOM	564.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40,182.14	2,752.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	31,443.42

TOTAL ANCILLARY	42,548,603.42	65,355.27
TOTAL ACCOMODATIONS	10,145,056.50	742,187.00
TOTAL CHARGES	52,693,659.92	807,542.27

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,360,559.46	ADJUSTMENTS	0.00
COVERED CHARGES	1,298,815.46	CONTRACTUAL ALLOW	712,598.61
NON-COVERED CHARGES	61,744.00	TOTAL MEDICAID LIAB	586,216.85
		LESS: COB	586,216.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 50

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	138	0	52,960.00	2,460.00
NURSERY CARE CHARGES	153	0	56,640.00	59,160.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	291	0	109,600.00	61,620.00
SPECIAL CARE SERVICES				
C C U	1	0	1,140.00	0.00
I C U	49	0	33,565.00	0.00
N I C U	212	0	241,680.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	262	0	276,385.00	0.00
TOTAL ACCOMODATIONS	553	0	385,985.00	61,620.00

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288,361.22	0.00
MED/SURG SUPPLY	291,357.59	0.00
LABORATORY-GENERAL	98,797.85	0.00
RADIOLOGY-DIAGNOSTIC	15,150.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	2,110.00	0.00
EKG/ECG	1,118.00	0.00
IV THERAPY	3,543.00	0.00
OPERATING ROOM	42,897.00	0.00
LABOR/DELIVERY ROOM	23,659.50	0.00
RESPIRATORY SERVICES	93,870.00	0.00
ANESTHESIA	3,303.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,472.00	0.00
RECOVERY ROOM	4,540.00	0.00
LABORATORY PATHOLOGIC	3,290.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	582.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,131.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,437.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	862.00	0.00
AUDIOLOGY	1,972.00	124.00
CARDIOLOGY	4,860.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,948.30	0.00
OTHER LAB SERVICES	1,689.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	8,113.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,767.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	912,830.46	124.00
TOTAL ACCOMODATIONS	385,985.00	61,620.00
TOTAL CHARGES	1,298,815.46	61,744.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,234,990.95	ADJUSTMENTS	356,156.94
COVERED CHARGES	18,721,815.33	CONTRACTUAL ALLOW	9,968,991.54
NON-COVERED CHARGES	513,175.62	TOTAL MEDICAID LIAB	8,752,823.79
		LESS: COB	80,932.54
		LESS: COPAYMENT	30,903.00
		REIMBURSEMENT	8,640,988.25
		ALL OTHER	8,154,859.61
		FEE SCHEDULE-LAB	486,128.64
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25,133

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,338,825.08	32,140.65
MED/SURG SUPPLY	1,909,792.36	20,092.75
LABORATORY-GENERAL	2,736.00	96,425.44
RADIOLOGY-DIAGNOSTIC	1,009,763.00	26,259.00
CT SCAN	1,108,594.00	7,346.00
PHYSICAL THERAPY	204,451.00	1,485.00
EKG/ECG	130,079.00	528.00
IV THERAPY	166,686.80	220.00
OPERATING ROOM	1,074,360.06	47,316.49
LABOR/DELIVERY ROOM	433,618.75	903.00
RESPIRATORY SERVICES	137,199.15	0.00
ANESTHESIA	115,291.00	1,008.00
GI SERVICES	148,803.00	1,180.00
EMERGENCY ROOM	4,578,222.80	6,438.00
RECOVERY ROOM	243,486.00	1,891.00
LABORATORY PATHOLOGIC	0.00	912.00
RADIOLOGY THERAPEUTIC	32,119.48	0.00
OCCUPATIONAL THERAPY	198,862.00	1,079.00
SPEECH PATHOLOGY	821,328.00	2,551.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	179,946.43	536.70
PSYCHIATRIC SERVICES	4,200.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	201,827.00	12,731.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,729.00	484.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	146,235.00	6,596.00
AUDIOLOGY	15,251.13	0.00
CARDIOLOGY	359,808.00	10,677.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	51,833.00	0.00
ORGAN ACQUISITION	0.00	2,075.00
TREATMENT/OBSERVATION	419,416.00	489.00
OTHER LAB SERVICES	253,867.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,537.50	0.00
OTHER THERAPEUTIC SERVI	24,170.50	6,778.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,859,012.79	222,067.59
MRI SERVICES	500,796.00	2,104.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	19,562.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	150.00
CAST ROOM	17,406.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	712.00

TOTAL ANCILLARY	18,721,815.33	513,175.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,721,815.33	513,175.62

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	64,299.12	ADJUSTMENTS	0.00
COVERED CHARGES	58,604.02	CONTRACTUAL ALLOW	24,453.13
NON-COVERED CHARGES	5,695.10	TOTAL MEDICAID LIAB	34,150.89
		LESS: COB	34,114.89
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,896.96-
		FEE SCHEDULE-LAB	1,896.96
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 63

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,681.89	452.83
MED/SURG SUPPLY	5,085.00	539.00
LABORATORY-GENERAL	0.00	651.75
RADIOLOGY-DIAGNOSTIC	1,143.00	158.00
CT SCAN	4,355.00	0.00
PHYSICAL THERAPY	1,350.00	0.00
EKG/ECG	132.00	0.00
IV THERAPY	568.90	128.00
OPERATING ROOM	2,552.00	0.00
LABOR/DELIVERY ROOM	613.00	0.00
RESPIRATORY SERVICES	0.00	792.00
ANESTHESIA	336.00	0.00
GI SERVICES	2,531.00	0.00
EMERGENCY ROOM	11,015.00	1,188.00
RECOVERY ROOM	436.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,094.00	0.00
SPEECH PATHOLOGY	6,682.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,208.00	414.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,784.23	1,134.52
MRI SERVICES	6,037.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	216.00

TOTAL ANCILLARY	58,604.02	5,674.10
TOTAL ACCOMODATIONS	0.00	21.00
TOTAL CHARGES	58,604.02	5,695.10

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	406,731.94	ADJUSTMENTS	1,560.28
COVERED CHARGES	402,226.94	CONTRACTUAL ALLOW	344,722.20
NON-COVERED CHARGES	4,505.00	TOTAL MEDICAID LIAB	57,504.74
		LESS: COB	91.59
		LESS: COPAYMENT	1,059.00
		REIMBURSEMENT	56,354.15

TOTAL NUMBER OF CLAIMS 1,153

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,413.59	0.00
MED/SURG SUPPLY	17,696.25	0.00
LABORATORY-GENERAL	30,188.00	4,035.00
RADIOLOGY-DIAGNOSTIC	14,488.00	0.00
CT SCAN	5,590.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,772.00	0.00
IV THERAPY	488.00	0.00
OPERATING ROOM	2,557.00	342.00
LABOR/DELIVERY ROOM	663.00	0.00
RESPIRATORY SERVICES	103.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	731.00	0.00
EMERGENCY ROOM	301,018.10	128.00
RECOVERY ROOM	565.00	0.00
LABORATORY PATHOLOGIC	155.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,442.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,215.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,808.00	0.00
OTHER LAB SERVICES	286.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	48.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	402,226.94	4,505.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	402,226.94	4,505.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,820.34	ADJUSTMENTS	0.00
COVERED CHARGES	6,082.34	CONTRACTUAL ALLOW	4,728.76
NON-COVERED CHARGES	738.00	TOTAL MEDICAID LIAB	1,353.58
		LESS: COB	1,347.58
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77.34	0.00
MED/SURG SUPPLY	86.00	0.00
LABORATORY-GENERAL	456.00	0.00
RADIOLOGY-DIAGNOSTIC	812.00	0.00
CT SCAN	2,036.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,615.00	738.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,082.34	738.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,082.34	738.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,334,031.26	ADJUSTMENTS	4,289.18
COVERED CHARGES	2,117,297.07	CONTRACTUAL ALLOW	1,461,710.78
NON-COVERED CHARGES	216,734.19	TOTAL MEDICAID LIAB	655,586.29
		LESS: COB	2,720.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	652,497.29

TOTAL NUMBER OF CLAIMS 153

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	638,956.21	3,787.72
MED/SURG SUPPLY	747,174.39	1,858.56
LABORATORY-GENERAL	228.00	2,550.85
RADIOLOGY-DIAGNOSTIC	164,101.00	62,448.00
CT SCAN	14,538.00	0.00
PHYSICAL THERAPY	1,098.00	0.00
EKG/ECG	4,356.00	0.00
IV THERAPY	9,866.00	0.00
OPERATING ROOM	288,848.94	19,220.06
LABOR/DELIVERY ROOM	5,285.75	0.00
RESPIRATORY SERVICES	740.00	0.00
ANESTHESIA	9,606.00	0.00
GI SERVICES	1,180.00	0.00
EMERGENCY ROOM	20,274.30	0.00
RECOVERY ROOM	21,545.00	0.00
LABORATORY PATHOLOGIC	0.00	273.00
RADIOLOGY THERAPEUTIC	12,048.48	0.00
OCCUPATIONAL THERAPY	162.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,974.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	23,026.00	0.00
OTHER IMAGING SERVICES	3,953.00	624.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	766.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,485.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	71,891.00	116,027.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	26,339.50	0.00
OTHER LAB SERVICES	830.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,961.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,677.50	4,688.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	347.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,296.00

TOTAL ANCILLARY	2,117,297.07	216,734.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,117,297.07	216,734.19

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,238.61	ADJUSTMENTS	0.00
COVERED CHARGES	7,375.61	CONTRACTUAL ALLOW	2,553.02
NON-COVERED CHARGES	863.00	TOTAL MEDICAID LIAB	4,822.59
		LESS: COB	4,819.59
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,241.61	0.00
MED/SURG SUPPLY	1,065.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,412.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	302.00	863.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	355.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,375.61	863.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,375.61	863.00

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	62,201,932.56	ADJUSTMENTS	4,741,255.46
COVERED CHARGES	61,295,347.63	CONTRACTUAL ALLOW	38,822,722.92
NON-COVERED CHARGES	906,584.93	TOTAL MEDICAID LIAB	22,472,624.71
		LESS: COB	479,140.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,993,484.44

TOTAL NUMBER OF ADMISSIONS 3,837

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8,797	0	3,624,830.00	182,055.00
NURSERY CARE CHARGES	4,213	0	1,640,214.00	696,379.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	16	0.00	0.00
TOTAL ROUTINE	13,010	16	5,265,044.00	878,434.00
SPECIAL CARE SERVICES				
C C U	380	0	464,020.00	0.00
I C U	2,891	0	2,494,465.00	0.00
N I C U	2,487	0	3,039,780.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,758	0	5,998,265.00	0.00
TOTAL ACCOMODATIONS	18,768	16	11,263,309.00	878,434.00

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,915,730.75	0.00
MED/SURG SUPPLY	12,921,435.85	1,346.00
LABORATORY-GENERAL	5,347,777.96	0.00
RADIOLOGY-DIAGNOSTIC	1,142,847.00	0.00
CT SCAN	867,102.00	0.00
PHYSICAL THERAPY	226,197.00	0.00
EKG/ECG	178,941.00	0.00
IV THERAPY	360,793.00	0.00
OPERATING ROOM	2,433,091.00	0.00
LABOR/DELIVERY ROOM	2,389,189.25	0.00
RESPIRATORY SERVICES	2,597,396.00	0.00
ANESTHESIA	215,379.00	0.00
GI SERVICES	152,900.00	0.00
EMERGENCY ROOM	895,027.20	0.00
RECOVERY ROOM	297,501.00	0.00
LABORATORY PATHOLOGIC	285,951.00	0.00
RADIOLOGY THERAPEUTIC	10,846.96	0.00
OCCUPATIONAL THERAPY	79,602.00	0.00
SPEECH PATHOLOGY	64,389.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	845.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	503,300.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	494,863.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	115,006.00	0.00
AUDIOLOGY	87,164.00	910.00
CARDIOLOGY	1,742,750.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,936.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	156,652.00	1,508.00
OTHER LAB SERVICES	221,107.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,611.00	0.00
OTHER THERAPEUTIC SERVI	100,294.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	139,190.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,149.80
CAST ROOM	447.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,621.66	0.00
HOME HEALTH SERVICES	0.00	1,579.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,943.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16,870.13

TOTAL ANCILLARY	50,032,038.63	28,150.93
TOTAL ACCOMODATIONS	11,263,309.00	878,434.00
TOTAL CHARGES	61,295,347.63	906,584.93

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,617,758.88	ADJUSTMENTS	0.00
COVERED CHARGES	1,585,772.88	CONTRACTUAL ALLOW	762,918.41
NON-COVERED CHARGES	31,986.00	TOTAL MEDICAID LIAB	822,854.47
		LESS: COB	822,854.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	212	0	86,920.00	5,170.00
NURSERY CARE CHARGES	106	0	46,442.00	25,990.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	318	0	133,362.00	31,160.00
SPECIAL CARE SERVICES				
C C U	16	0	19,520.00	0.00
I C U	72	0	61,635.00	0.00
N I C U	132	0	164,640.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	220	0	245,795.00	0.00
TOTAL ACCOMODATIONS	538	0	379,157.00	31,160.00

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,294.07	0.00
MED/SURG SUPPLY	314,650.00	0.00
LABORATORY-GENERAL	174,654.75	0.00
RADIOLOGY-DIAGNOSTIC	20,475.00	0.00
CT SCAN	6,317.00	0.00
PHYSICAL THERAPY	3,230.00	0.00
EKG/ECG	1,818.00	0.00
IV THERAPY	9,478.00	0.00
OPERATING ROOM	53,726.00	0.00
LABOR/DELIVERY ROOM	96,641.00	0.00
RESPIRATORY SERVICES	85,939.00	0.00
ANESTHESIA	7,123.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,124.00	0.00
RECOVERY ROOM	10,150.00	0.00
LABORATORY PATHOLOGIC	10,606.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,627.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,334.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,088.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,353.00	490.00
CARDIOLOGY	14,708.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,540.00	0.00
OTHER LAB SERVICES	9,531.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	5,494.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,891.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,824.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	336.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,206,615.88	826.00
TOTAL ACCOMODATIONS	379,157.00	31,160.00
TOTAL CHARGES	1,585,772.88	31,986.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,092,529.97	ADJUSTMENTS	624,742.18
COVERED CHARGES	19,519,172.47	CONTRACTUAL ALLOW	13,017,293.13
NON-COVERED CHARGES	573,357.50	TOTAL MEDICAID LIAB	6,501,879.34
		LESS: COB	33,859.66
		LESS: COPAYMENT	19,089.00
		REIMBURSEMENT	6,448,930.68
		ALL OTHER	5,928,760.68
		FEE SCHEDULE-LAB	520,170.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25,371

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,962,429.33	1,616.50
MED/SURG SUPPLY	2,533,016.86	959.00
LABORATORY-GENERAL	4,981.00	169,646.65
RADIOLOGY-DIAGNOSTIC	1,064,089.00	26,165.00
CT SCAN	1,137,473.00	34,871.00
PHYSICAL THERAPY	157,275.00	1,514.00
EKG/ECG	138,390.00	0.00
IV THERAPY	145,183.00	0.00
OPERATING ROOM	1,238,379.65	26,558.35
LABOR/DELIVERY ROOM	538,740.00	7,376.00
RESPIRATORY SERVICES	146,828.00	193.00
ANESTHESIA	154,482.00	147.00
GI SERVICES	214,777.00	3,824.00
EMERGENCY ROOM	4,389,435.80	5,276.00
RECOVERY ROOM	249,879.00	240.00
LABORATORY PATHOLOGIC	0.00	468.00
RADIOLOGY THERAPEUTIC	4,823.00	0.00
OCCUPATIONAL THERAPY	186,526.00	1,586.00
SPEECH PATHOLOGY	857,037.00	0.00
RENAL DIALYSIS	0.00	474.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	125,677.50	433.90
PSYCHIATRIC SERVICES	2,310.00	0.00
LITHOTRIPSY	37,995.00	0.00
OTHER IMAGING SERVICES	218,513.00	16,941.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,084.00	1,035.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	162,136.00	2,219.00
AUDIOLOGY	19,142.30	0.00
CARDIOLOGY	464,681.00	4,920.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	65,363.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	429,789.30	2,268.00
OTHER LAB SERVICES	250,646.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,794.50	113.00
OTHER THERAPEUTIC SERVI	21,315.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,983,025.23	250,711.23
MRI SERVICES	539,729.00	1,891.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	23,931.00	129.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	18,296.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	40.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	552.30
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11,189.57

TOTAL ANCILLARY	19,519,172.47	573,357.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,519,172.47	573,357.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	81,533.89	ADJUSTMENTS	0.00
COVERED CHARGES	70,829.24	CONTRACTUAL ALLOW	40,799.34
NON-COVERED CHARGES	10,704.65	TOTAL MEDICAID LIAB	30,029.90
		LESS: COB	29,984.90
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,387.27-
		FEE SCHEDULE-LAB	1,387.27
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,449.74	84.15
MED/SURG SUPPLY	7,125.00	0.00
LABORATORY-GENERAL	0.00	208.00
RADIOLOGY-DIAGNOSTIC	2,760.00	170.00
CT SCAN	2,240.00	1,120.00
PHYSICAL THERAPY	965.00	0.00
EKG/ECG	1,488.00	0.00
IV THERAPY	472.00	0.00
OPERATING ROOM	4,213.00	0.00
LABOR/DELIVERY ROOM	1,377.00	0.00
RESPIRATORY SERVICES	108.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,298.00	0.00
EMERGENCY ROOM	12,585.00	769.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,663.00	6,975.00
SPEECH PATHOLOGY	16,645.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	476.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	402.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	656.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	138.00	0.00
OTHER LAB SERVICES	2,005.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,872.50	1,378.50
MRI SERVICES	1,891.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,829.24	10,704.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,829.24	10,704.65

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	588,467.39	ADJUSTMENTS	1,479.00
COVERED CHARGES	583,573.39	CONTRACTUAL ALLOW	504,671.59
NON-COVERED CHARGES	4,894.00	TOTAL MEDICAID LIAB	78,901.80
		LESS: COB	86.52
		LESS: COPAYMENT	2,109.00
		REIMBURSEMENT	76,706.28

TOTAL NUMBER OF CLAIMS 1,603

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,733.06	0.00
MED/SURG SUPPLY	25,912.73	27.00
LABORATORY-GENERAL	45,301.50	4,867.00
RADIOLOGY-DIAGNOSTIC	26,162.00	0.00
CT SCAN	10,080.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,504.00	0.00
IV THERAPY	220.00	0.00
OPERATING ROOM	2,085.00	0.00
LABOR/DELIVERY ROOM	1,605.00	0.00
RESPIRATORY SERVICES	661.00	0.00
ANESTHESIA	185.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	431,708.10	0.00
RECOVERY ROOM	405.00	0.00
LABORATORY PATHOLOGIC	352.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,682.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	340.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,118.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,712.00	0.00
OTHER LAB SERVICES	731.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	76.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	583,573.39	4,894.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	583,573.39	4,894.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,738.14	ADJUSTMENTS	0.00
COVERED CHARGES	4,723.14	CONTRACTUAL ALLOW	3,820.74
NON-COVERED CHARGES	15.00	TOTAL MEDICAID LIAB	902.40
		LESS: COB	899.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	614.14	0.00
MED/SURG SUPPLY	490.00	0.00
LABORATORY-GENERAL	213.00	15.00
RADIOLOGY-DIAGNOSTIC	189.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	146.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	93.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,798.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	180.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,723.14	15.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,723.14	15.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,660,066.33	ADJUSTMENTS	44,068.78
COVERED CHARGES	1,574,962.77	CONTRACTUAL ALLOW	1,306,100.03
NON-COVERED CHARGES	85,103.56	TOTAL MEDICAID LIAB	268,862.74
		LESS: COB	0.00
		LESS: COPAYMENT	201.00
		REIMBURSEMENT	268,661.74

TOTAL NUMBER OF CLAIMS 67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,625.19	2,907.56
MED/SURG SUPPLY	742,625.08	0.00
LABORATORY-GENERAL	488.00	67.00
RADIOLOGY-DIAGNOSTIC	168,042.00	16,596.00
CT SCAN	6,527.00	0.00
PHYSICAL THERAPY	3,475.00	0.00
EKG/ECG	6,132.00	0.00
IV THERAPY	289.00	0.00
OPERATING ROOM	294,720.00	5,368.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	284.00	0.00
ANESTHESIA	7,265.00	0.00
GI SERVICES	0.00	325.00
EMERGENCY ROOM	6,248.00	0.00
RECOVERY ROOM	11,068.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	300.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,665.00	0.00
OTHER IMAGING SERVICES	4,645.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,032.00	110.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,597.00	56,339.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	40,628.00	0.00
OTHER LAB SERVICES	532.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	34.00	0.00
OTHER THERAPEUTIC SERVI	220.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,885.50	3,391.00
MRI SERVICES	4,636.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,574,962.77	85,103.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,574,962.77	85,103.56

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	57,731,245.49	ADJUSTMENTS	5,453,250.20
COVERED CHARGES	57,155,073.36	CONTRACTUAL ALLOW	37,279,520.99
NON-COVERED CHARGES	576,172.13	TOTAL MEDICAID LIAB	19,875,552.37
		LESS: COB	337,472.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,538,079.39

TOTAL NUMBER OF ADMISSIONS 3,102

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7,682	0	3,495,415.00	4,280.00
NURSERY CARE CHARGES	3,424	0	1,436,389.00	551,105.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	14	0.00	0.00
TOTAL ROUTINE	11,106	14	4,931,804.00	555,385.00
SPECIAL CARE SERVICES				
C C U	342	0	438,865.00	0.00
I C U	2,838	0	2,543,820.00	0.00
N I C U	2,163	0	2,768,640.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,343	0	5,751,325.00	0.00
TOTAL ACCOMODATIONS	16,449	14	10,683,129.00	555,385.00

INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,070,792.00	0.00
MED/SURG SUPPLY	10,824,162.46	1,245.00
LABORATORY-GENERAL	5,216,347.85	0.00
RADIOLOGY-DIAGNOSTIC	1,056,945.00	0.00
CT SCAN	828,950.00	0.00
PHYSICAL THERAPY	236,500.00	0.00
EKG/ECG	157,048.00	0.00
IV THERAPY	318,956.00	0.00
OPERATING ROOM	2,064,048.00	0.00
LABOR/DELIVERY ROOM	2,176,698.00	0.00
RESPIRATORY SERVICES	3,061,457.00	0.00
ANESTHESIA	188,379.00	0.00
GI SERVICES	177,521.00	0.00
EMERGENCY ROOM	643,813.00	0.00
RECOVERY ROOM	263,375.00	0.00
LABORATORY PATHOLOGIC	244,548.00	0.00
RADIOLOGY THERAPEUTIC	8,361.47	0.00
OCCUPATIONAL THERAPY	77,200.00	0.00
SPEECH PATHOLOGY	97,975.00	0.00
RENAL DIALYSIS	20,916.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	155.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	477,922.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	400,512.00	5,137.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	94,412.00	0.00
AUDIOLOGY	82,957.00	711.00
CARDIOLOGY	1,309,627.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,320.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	240,582.00	145.00
OTHER LAB SERVICES	150,713.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,146.00	0.00
OTHER THERAPEUTIC SERVI	89,947.00	573.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	177,569.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	5,224.00
CAST ROOM	360.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,691,884.58	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,597.13

TOTAL ANCILLARY	46,471,944.36	20,787.13
TOTAL ACCOMODATIONS	10,683,129.00	555,385.00
TOTAL CHARGES	57,155,073.36	576,172.13

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,639,793.29	ADJUSTMENTS	0.00
COVERED CHARGES	2,625,542.29	CONTRACTUAL ALLOW	2,155,285.46
NON-COVERED CHARGES	14,251.00	TOTAL MEDICAID LIAB	470,256.83
		LESS: COB	470,256.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	245	0	111,475.00	0.00
NURSERY CARE CHARGES	41	0	16,622.00	10,670.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	286	3	128,097.00	10,670.00
SPECIAL CARE SERVICES				
C C U	81	0	106,085.00	0.00
I C U	157	4	139,955.00	3,060.00
N I C U	53	0	67,840.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	291	4	313,880.00	3,060.00
TOTAL ACCOMODATIONS	577	7	441,977.00	13,730.00

ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	670,124.70	0.00
MED/SURG SUPPLY	496,475.11	0.00
LABORATORY-GENERAL	257,490.25	0.00
RADIOLOGY-DIAGNOSTIC	46,355.00	0.00
CT SCAN	34,021.00	0.00
PHYSICAL THERAPY	8,503.00	0.00
EKG/ECG	3,555.00	0.00
IV THERAPY	13,478.00	0.00
OPERATING ROOM	69,390.00	0.00
LABOR/DELIVERY ROOM	106,824.00	0.00
RESPIRATORY SERVICES	247,476.00	0.00
ANESTHESIA	7,661.00	0.00
GI SERVICES	1,182.00	0.00
EMERGENCY ROOM	8,038.00	0.00
RECOVERY ROOM	9,725.00	0.00
LABORATORY PATHOLOGIC	10,021.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,210.00	0.00
SPEECH PATHOLOGY	1,544.00	0.00
RENAL DIALYSIS	46,776.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	126.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,706.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,327.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	864.00	0.00
AUDIOLOGY	158.00	395.00
CARDIOLOGY	19,938.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	690.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	26,904.00	0.00
OTHER LAB SERVICES	5,246.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	165.00	0.00
OTHER THERAPEUTIC SERVI	278.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,826.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30,613.73	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,183,565.29	521.00
TOTAL ACCOMODATIONS	441,977.00	13,730.00
TOTAL CHARGES	2,625,542.29	14,251.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	17,836,725.77	ADJUSTMENTS	369,863.85
COVERED CHARGES	17,055,873.98	CONTRACTUAL ALLOW	12,550,162.40
NON-COVERED CHARGES	780,851.79	TOTAL MEDICAID LIAB	4,505,711.58
		LESS: COB	20,656.32
		LESS: COPAYMENT	17,262.00
		REIMBURSEMENT	4,467,793.26
		ALL OTHER	3,963,923.65
		FEE SCHEDULE-LAB	503,868.27
		INJECTABLE DRUGS	1.34

TOTAL NUMBER OF CLAIMS 19,535

OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,345,182.19	8.01
MED/SURG SUPPLY	2,320,486.65	1,626.61
LABORATORY-GENERAL	720.00	161,696.27
RADIOLOGY-DIAGNOSTIC	842,524.00	27,550.00
CT SCAN	1,038,832.00	109,545.00
PHYSICAL THERAPY	102,151.00	2,269.00
EKG/ECG	132,737.00	0.00
IV THERAPY	281,353.00	0.00
OPERATING ROOM	976,776.94	29,032.07
LABOR/DELIVERY ROOM	503,441.00	19,744.00
RESPIRATORY SERVICES	139,618.00	6,466.00
ANESTHESIA	123,511.01	0.00
GI SERVICES	150,648.50	2,533.50
EMERGENCY ROOM	3,268,430.12	13,113.00
RECOVERY ROOM	198,335.60	5,945.00
LABORATORY PATHOLOGIC	0.00	205.00
RADIOLOGY THERAPEUTIC	1,810.00	0.00
OCCUPATIONAL THERAPY	191,486.00	233.00
SPEECH PATHOLOGY	728,967.00	726.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	119,953.00	2,087.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	250,462.00	25,804.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	94,196.00	5,643.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	98,830.00	1,160.00
AUDIOLOGY	20,080.90	0.00
CARDIOLOGY	377,866.00	15,848.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	60,280.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	520,626.00	3,622.00
OTHER LAB SERVICES	244,743.00	324.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,454.50	238.00
OTHER THERAPEUTIC SERVI	17,343.00	2,275.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,477,758.27	312,002.00
MRI SERVICES	400,940.00	1,986.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	12,104.00	1,768.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	12,149.00	127.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78.30	21,989.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	275.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,010.55

TOTAL ANCILLARY	17,055,873.98	780,851.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,055,873.98	780,851.79

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	85,116.76	ADJUSTMENTS	0.00
COVERED CHARGES	70,430.72	CONTRACTUAL ALLOW	42,397.50
NON-COVERED CHARGES	14,686.04	TOTAL MEDICAID LIAB	28,033.22
		LESS: COB	28,000.22
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,158.49-
		FEE SCHEDULE-LAB	2,158.49
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,473.50	0.00
MED/SURG SUPPLY	7,963.00	1,787.00
LABORATORY-GENERAL	0.00	497.00
RADIOLOGY-DIAGNOSTIC	1,542.00	0.00
CT SCAN	2,816.00	3,528.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	616.00	0.00
IV THERAPY	2,412.00	0.00
OPERATING ROOM	1,278.00	4,331.00
LABOR/DELIVERY ROOM	1,647.00	0.00
RESPIRATORY SERVICES	114.00	0.00
ANESTHESIA	722.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,168.00	0.00
RECOVERY ROOM	611.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,792.00	0.00
SPEECH PATHOLOGY	4,223.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	205.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,649.00	405.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,708.00	270.00
OTHER LAB SERVICES	1,037.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,020.22	1,580.00
MRI SERVICES	2,434.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	393.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,895.00

TOTAL ANCILLARY	70,430.72	14,686.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,430.72	14,686.04

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	866,941.49	ADJUSTMENTS	1,913.62
COVERED CHARGES	853,867.67	CONTRACTUAL ALLOW	749,964.79
NON-COVERED CHARGES	13,073.82	TOTAL MEDICAID LIAB	103,902.88
		LESS: COB	19.29
		LESS: COPAYMENT	2,910.00
		REIMBURSEMENT	100,973.59

TOTAL NUMBER OF CLAIMS 2,119

OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,949.78	0.00
MED/SURG SUPPLY	47,260.56	0.00
LABORATORY-GENERAL	77,524.00	5,976.00
RADIOLOGY-DIAGNOSTIC	44,034.00	0.00
CT SCAN	9,706.00	4,928.00
PHYSICAL THERAPY	855.00	0.00
EKG/ECG	4,312.00	0.00
IV THERAPY	9,082.00	0.00
OPERATING ROOM	2,221.00	0.00
LABOR/DELIVERY ROOM	2,851.00	0.00
RESPIRATORY SERVICES	333.00	0.00
ANESTHESIA	287.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	598,944.00	166.00
RECOVERY ROOM	378.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	329.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	208.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,334.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,174.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,084.00	27.00
OTHER LAB SERVICES	1,078.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	405.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,317.03	112.55
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	528.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78.30	1,459.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	853,867.67	13,073.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	853,867.67	13,073.82

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,526.95	ADJUSTMENTS	0.00
COVERED CHARGES	5,209.95	CONTRACTUAL ALLOW	4,934.62
NON-COVERED CHARGES	317.00	TOTAL MEDICAID LIAB	275.33
		LESS: COB	263.33
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.35	0.00
MED/SURG SUPPLY	1,022.00	0.00
LABORATORY-GENERAL	1,133.00	317.00
RADIOLOGY-DIAGNOSTIC	179.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	154.00	0.00
IV THERAPY	250.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,210.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	156.60	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,209.95	317.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,209.95	317.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,293,021.94	ADJUSTMENTS	11,005.62
COVERED CHARGES	2,160,167.62	CONTRACTUAL ALLOW	1,844,119.11
NON-COVERED CHARGES	132,854.32	TOTAL MEDICAID LIAB	316,048.51
		LESS: COB	0.00
		LESS: COPAYMENT	324.00
		REIMBURSEMENT	315,724.51

TOTAL NUMBER OF CLAIMS 86

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0142GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,551.64	0.00
MED/SURG SUPPLY	886,482.72	5,943.00
LABORATORY-GENERAL	0.00	313.00
RADIOLOGY-DIAGNOSTIC	251,912.00	21,185.00
CT SCAN	7,068.00	644.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,468.00	0.00
IV THERAPY	5,965.00	0.00
OPERATING ROOM	504,999.54	36,325.46
LABOR/DELIVERY ROOM	2,889.00	0.00
RESPIRATORY SERVICES	1,930.00	0.00
ANESTHESIA	7,928.00	0.00
GI SERVICES	0.00	4,383.00
EMERGENCY ROOM	7,131.00	0.00
RECOVERY ROOM	12,804.00	0.00
LABORATORY PATHOLOGIC	0.00	41.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	26,598.00	0.00
OTHER IMAGING SERVICES	7,760.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,994.00	581.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	98,788.00	56,245.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	40,565.00	0.00
OTHER LAB SERVICES	1,846.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	36.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	99,451.72	6,385.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	808.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,160,167.62	132,854.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,160,167.62	132,854.32

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA GA 30901-2612

PROVIDER NUMBER 000001977A
NUMBER OF BEDS 551
TITLE XVIII NO: HPH0142GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	10,609,814.73	ADJUSTMENTS	306,866.01
COVERED CHARGES	10,359,248.23	CONTRACTUAL ALLOW	4,587,019.26
NON-COVERED CHARGES	250,566.50	TOTAL MEDICAID LIAB	5,772,228.97
		LESS: COB	62,086.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,710,142.92

TOTAL NUMBER OF ADMISSIONS 1,582

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,207	0	1,520,015.00	230,910.00
NURSERY CARE CHARGES	505	0	167,203.00	235.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,712	0	1,687,218.00	231,145.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	370	0	411,960.00	0.00
N I C U	772	0	621,066.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,142	0	1,033,026.00	0.00
TOTAL ACCOMODATIONS	4,854	0	2,720,244.00	231,145.00

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,531,822.25	0.00
MED/SURG SUPPLY	1,053,952.10	10,770.00
LABORATORY-GENERAL	1,248,181.85	0.00
RADIOLOGY-DIAGNOSTIC	201,871.75	0.00
CT SCAN	297,930.00	0.00
PHYSICAL THERAPY	57,639.00	0.00
EKG/ECG	31,500.00	0.00
IV THERAPY	43,560.00	0.00
OPERATING ROOM	922,958.67	0.00
LABOR/DELIVERY ROOM	724,126.50	0.00
RESPIRATORY SERVICES	118,031.00	0.00
ANESTHESIA	43,126.00	23.00
GI SERVICES	58,156.00	0.00
EMERGENCY ROOM	337,758.00	0.00
RECOVERY ROOM	263,302.00	0.00
LABORATORY PATHOLOGIC	46,101.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,709.50	0.00
SPEECH PATHOLOGY	1,146.00	0.00
RENAL DIALYSIS	13,777.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	25,836.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	202,942.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,561.00	0.00
AUDIOLOGY	19,784.50	0.00
CARDIOLOGY	77,525.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,501.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,306.60	7,560.50
OTHER LAB SERVICES	14,134.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	531.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	38,670.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	182,094.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	537.00

TOTAL ANCILLARY	7,639,004.23	19,421.50
TOTAL ACCOMODATIONS	2,720,244.00	231,145.00
TOTAL CHARGES	10,359,248.23	250,566.50

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	10,799.75	ADJUSTMENTS	0.00
COVERED CHARGES	10,576.75	CONTRACTUAL ALLOW	1,792.44
NON-COVERED CHARGES	223.00	TOTAL MEDICAID LIAB	8,784.31
		LESS: COB	8,784.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	953.00	223.00
NURSERY CARE CHARGES	2	0	660.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,613.00	223.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	5	0	4,020.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,020.00	0.00
TOTAL ACCOMODATIONS	9	0	5,633.00	223.00

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.50	0.00
MED/SURG SUPPLY	1,319.50	0.00
LABORATORY-GENERAL	1,719.00	0.00
RADIOLOGY-DIAGNOSTIC	177.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	734.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	135.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	81.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,943.75	0.00
TOTAL ACCOMODATIONS	5,633.00	223.00
TOTAL CHARGES	10,576.75	223.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,866,626.45	ADJUSTMENTS	300,833.48
COVERED CHARGES	9,553,065.38	CONTRACTUAL ALLOW	5,768,174.74
NON-COVERED CHARGES	313,561.07	TOTAL MEDICAID LIAB	3,784,890.64
		LESS: COB	3,203.78
		LESS: COPAYMENT	8,574.00
		REIMBURSEMENT	3,773,112.86
		ALL OTHER	3,543,255.02
		FEE SCHEDULE-LAB	223,543.70
		INJECTABLE DRUGS	6,314.14

TOTAL NUMBER OF CLAIMS 11,771

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	654,121.50	25,630.00
MED/SURG SUPPLY	529,110.80	3,382.50
LABORATORY-GENERAL	4,960.00	10,218.25
RADIOLOGY-DIAGNOSTIC	665,111.75	23,164.00
CT SCAN	1,067,800.75	8,025.50
PHYSICAL THERAPY	278,335.07	818.00
EKG/ECG	70,695.00	569.00
IV THERAPY	21,039.00	0.00
OPERATING ROOM	790,761.25	6,090.00
LABOR/DELIVERY ROOM	307,807.00	1,782.00
RESPIRATORY SERVICES	21,587.75	298.00
ANESTHESIA	57,460.00	0.00
GI SERVICES	79,693.00	5,940.00
EMERGENCY ROOM	2,087,848.96	12,971.25
RECOVERY ROOM	268,941.00	0.00
LABORATORY PATHOLOGIC	0.00	195.75
RADIOLOGY THERAPEUTIC	9,176.00	592.00
OCCUPATIONAL THERAPY	29,219.00	437.00
SPEECH PATHOLOGY	169.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,004.50	0.00
OTHER IMAGING SERVICES	126,734.00	760.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,267.00	6,225.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	139,636.00	0.00
AUDIOLOGY	67.50	0.00
CARDIOLOGY	103,345.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	81,267.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	260,420.70	3,344.10
OTHER LAB SERVICES	48,136.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	224.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,703.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,482,349.10	177,619.50
MRI SERVICES	277,600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	60,177.25	21,371.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,423.00

TOTAL ANCILLARY	9,553,065.38	313,561.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,553,065.38	313,561.07

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,386.25	ADJUSTMENTS	0.00
COVERED CHARGES	11,900.75	CONTRACTUAL ALLOW	9,051.54
NON-COVERED CHARGES	485.50	TOTAL MEDICAID LIAB	2,849.21
		LESS: COB	2,843.21
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	378.36-
		FEE SCHEDULE-LAB	378.36
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,631.00	0.00
MED/SURG SUPPLY	200.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,059.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	158.00	95.00
IV THERAPY	213.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,277.00	0.00
RESPIRATORY SERVICES	59.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,865.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,005.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,398.50	376.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35.25	14.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,900.75	485.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,900.75	485.50

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	570,952.56	ADJUSTMENTS	1,088.00
COVERED CHARGES	563,850.31	CONTRACTUAL ALLOW	494,628.31
NON-COVERED CHARGES	7,102.25	TOTAL MEDICAID LIAB	69,222.00
		LESS: COB	19.96
		LESS: COPAYMENT	1,233.00
		REIMBURSEMENT	67,969.04

TOTAL NUMBER OF CLAIMS 1,385

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,663.00	12.00
MED/SURG SUPPLY	10,066.00	42.00
LABORATORY-GENERAL	73,466.50	3,892.50
RADIOLOGY-DIAGNOSTIC	37,347.50	260.00
CT SCAN	30,262.50	0.00
PHYSICAL THERAPY	336.00	0.00
EKG/ECG	1,580.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,782.00	0.00
RESPIRATORY SERVICES	1,503.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	363,540.56	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,832.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,687.50	0.00
OTHER LAB SERVICES	654.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,495.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,634.75	2,895.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	563,850.31	7,102.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	563,850.31	7,102.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,210.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,645.00	CONTRACTUAL ALLOW	2,267.17
NON-COVERED CHARGES	565.50	TOTAL MEDICAID LIAB	2,377.83
		LESS: COB	2,368.83
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72.00	0.00
MED/SURG SUPPLY	35.25	0.00
LABORATORY-GENERAL	358.00	166.50
RADIOLOGY-DIAGNOSTIC	309.00	0.00
CT SCAN	2,694.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,155.50	399.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,645.00	565.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,645.00	565.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	280,254.00	ADJUSTMENTS	7,959.42
COVERED CHARGES	272,931.25	CONTRACTUAL ALLOW	177,382.21
NON-COVERED CHARGES	7,322.75	TOTAL MEDICAID LIAB	95,549.04
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	95,522.04

TOTAL NUMBER OF CLAIMS 24

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,811.50	737.25
MED/SURG SUPPLY	63,165.50	0.00
LABORATORY-GENERAL	0.00	94.00
RADIOLOGY-DIAGNOSTIC	6,274.50	3,301.00
CT SCAN	22,110.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	806.00	0.00
IV THERAPY	852.00	0.00
OPERATING ROOM	69,075.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	535.00	0.00
ANESTHESIA	3,992.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,003.50	0.00
RECOVERY ROOM	16,273.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,362.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,004.50	0.00
OTHER IMAGING SERVICES	1,110.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,218.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,056.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,608.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,418.00	0.00
OTHER LAB SERVICES	953.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,670.50	2,633.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	631.25	161.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	396.00

TOTAL ANCILLARY	272,931.25	7,322.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	272,931.25	7,322.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,297,352.49	ADJUSTMENTS	238,442.59
COVERED CHARGES	13,026,414.99	CONTRACTUAL ALLOW	6,666,372.88
NON-COVERED CHARGES	270,937.50	TOTAL MEDICAID LIAB	6,360,042.11
		LESS: COB	45,526.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,314,515.14

TOTAL NUMBER OF ADMISSIONS 1,735

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,347	0	1,989,820.00	238,255.00
NURSERY CARE CHARGES	577	0	219,530.00	25.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,924	0	2,209,350.00	238,280.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	456	0	709,840.00	0.00
N I C U	834	0	775,620.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,290	0	1,485,460.00	0.00
TOTAL ACCOMODATIONS	5,214	0	3,694,810.00	238,280.00

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,646,580.60	0.00
MED/SURG SUPPLY	1,063,769.11	11,339.00
LABORATORY-GENERAL	1,791,022.00	0.00
RADIOLOGY-DIAGNOSTIC	215,066.00	0.00
CT SCAN	401,652.00	0.00
PHYSICAL THERAPY	72,163.25	0.00
EKG/ECG	38,523.00	0.00
IV THERAPY	104,788.00	0.00
OPERATING ROOM	1,112,480.64	0.00
LABOR/DELIVERY ROOM	928,303.00	0.00
RESPIRATORY SERVICES	250,653.00	0.00
ANESTHESIA	47,481.00	0.00
GI SERVICES	56,822.00	0.00
EMERGENCY ROOM	453,116.50	0.00
RECOVERY ROOM	292,305.00	0.00
LABORATORY PATHOLOGIC	47,688.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	8,197.00	0.00
SPEECH PATHOLOGY	2,651.00	0.00
RENAL DIALYSIS	28,615.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,635.00	0.00
OTHER IMAGING SERVICES	68,080.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	157,312.50	976.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,913.00	0.00
AUDIOLOGY	39,768.50	0.00
CARDIOLOGY	94,818.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,940.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,838.00	7,857.00
OTHER LAB SERVICES	15,738.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	7,532.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	85,098.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	234,587.14	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	85.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,868.50

TOTAL ANCILLARY	9,331,604.99	32,657.50
TOTAL ACCOMODATIONS	3,694,810.00	238,280.00
TOTAL CHARGES	13,026,414.99	270,937.50

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,732.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,597.00	CONTRACTUAL ALLOW	200.00
NON-COVERED CHARGES	135.00	TOTAL MEDICAID LIAB	1,397.00
		LESS: COB	1,397.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	0	540.00	135.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	540.00	135.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	540.00	135.00

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	196.50	0.00
MED/SURG SUPPLY	44.50	0.00
LABORATORY-GENERAL	480.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	336.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,057.00	0.00
TOTAL ACCOMODATIONS	540.00	135.00
TOTAL CHARGES	1,597.00	135.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,336,403.02	ADJUSTMENTS	468,864.69
COVERED CHARGES	12,004,638.14	CONTRACTUAL ALLOW	7,899,091.58
NON-COVERED CHARGES	331,764.88	TOTAL MEDICAID LIAB	4,105,546.56
		LESS: COB	4,945.77
		LESS: COPAYMENT	5,811.00
		REIMBURSEMENT	4,094,789.79
		ALL OTHER	3,785,232.45
		FEE SCHEDULE-LAB	282,865.98
		INJECTABLE DRUGS	26,691.36

TOTAL NUMBER OF CLAIMS 13,590

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	736,941.67	8,451.83
MED/SURG SUPPLY	481,330.55	2,586.75
LABORATORY-GENERAL	7,520.00	10,631.25
RADIOLOGY-DIAGNOSTIC	760,470.00	9,997.00
CT SCAN	1,383,750.00	20,799.00
PHYSICAL THERAPY	354,015.00	962.25
EKG/ECG	89,658.00	87.00
IV THERAPY	42,363.00	0.00
OPERATING ROOM	781,183.37	7,970.00
LABOR/DELIVERY ROOM	550,643.50	933.00
RESPIRATORY SERVICES	39,077.00	0.00
ANESTHESIA	59,879.00	0.00
GI SERVICES	78,984.00	0.00
EMERGENCY ROOM	2,797,565.50	1,984.00
RECOVERY ROOM	260,805.00	0.00
LABORATORY PATHOLOGIC	0.00	125.00
RADIOLOGY THERAPEUTIC	16,342.00	270.00
OCCUPATIONAL THERAPY	51,774.00	368.00
SPEECH PATHOLOGY	3,204.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,612.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	259,349.00	2,207.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,582.00	6,344.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	133,522.00	0.00
AUDIOLOGY	639.00	0.00
CARDIOLOGY	109,727.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	67,726.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	375,680.00	12,626.00
OTHER LAB SERVICES	67,102.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	9,353.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,109,760.32	205,719.30
MRI SERVICES	293,681.00	7,803.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	384.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	70,367.48	19,439.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,108.00

TOTAL ANCILLARY	12,004,638.14	331,764.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,004,638.14	331,764.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	22,073.75	ADJUSTMENTS	0.00
COVERED CHARGES	19,760.30	CONTRACTUAL ALLOW	15,193.78
NON-COVERED CHARGES	2,313.45	TOTAL MEDICAID LIAB	4,566.52
		LESS: COB	4,551.52
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	903.85-
		FEE SCHEDULE-LAB	887.11
		INJECTABLE DRUGS	16.74

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	543.50	0.00
MED/SURG SUPPLY	656.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,670.00	838.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	593.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,745.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,188.00	0.00
EMERGENCY ROOM	5,259.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	195.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	406.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,650.30	1,251.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	48.75	3.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	26.00

TOTAL ANCILLARY	19,760.30	2,313.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,760.30	2,313.45

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	592,916.66	ADJUSTMENTS	2,094.70
COVERED CHARGES	586,463.41	CONTRACTUAL ALLOW	512,710.74
NON-COVERED CHARGES	6,453.25	TOTAL MEDICAID LIAB	73,752.67
		LESS: COB	106.75
		LESS: COPAYMENT	1,812.00
		REIMBURSEMENT	71,833.92

TOTAL NUMBER OF CLAIMS 1,475

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,201.16	144.75
MED/SURG SUPPLY	8,292.00	0.00
LABORATORY-GENERAL	72,996.25	2,395.00
RADIOLOGY-DIAGNOSTIC	37,572.00	435.00
CT SCAN	14,059.00	0.00
PHYSICAL THERAPY	872.75	0.00
EKG/ECG	2,118.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	9,828.50	0.00
RESPIRATORY SERVICES	1,873.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	394,068.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,432.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,254.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	594.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,169.00	0.00
OTHER LAB SERVICES	1,537.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12.00	0.00
MRI SERVICES	2,762.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,822.75	3,478.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	586,463.41	6,453.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	586,463.41	6,453.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,257.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,064.75	CONTRACTUAL ALLOW	2,935.58
NON-COVERED CHARGES	193.00	TOTAL MEDICAID LIAB	129.17
		LESS: COB	126.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103.25	0.00
MED/SURG SUPPLY	6.00	0.00
LABORATORY-GENERAL	437.00	0.00
RADIOLOGY-DIAGNOSTIC	1,397.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,069.00	180.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52.50	13.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,064.75	193.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,064.75	193.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	350,142.56	ADJUSTMENTS	24,194.78
COVERED CHARGES	344,865.81	CONTRACTUAL ALLOW	238,238.02
NON-COVERED CHARGES	5,276.75	TOTAL MEDICAID LIAB	106,627.79
		LESS: COB	2,880.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	103,711.79

TOTAL NUMBER OF CLAIMS 29

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,170.14	0.00
MED/SURG SUPPLY	73,926.35	0.00
LABORATORY-GENERAL	0.00	114.00
RADIOLOGY-DIAGNOSTIC	6,195.00	1,341.00
CT SCAN	29,155.00	0.00
PHYSICAL THERAPY	684.00	0.00
EKG/ECG	1,131.00	0.00
IV THERAPY	2,697.00	0.00
OPERATING ROOM	66,577.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	294.00	0.00
ANESTHESIA	4,089.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,630.00	0.00
RECOVERY ROOM	17,100.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,830.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	19,270.00	0.00
OTHER IMAGING SERVICES	2,591.00	112.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,371.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,089.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,044.00	0.00
OTHER LAB SERVICES	802.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	308.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,449.32	2,952.00
MRI SERVICES	11,165.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	606.00	449.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	344,865.81	5,276.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	344,865.81	5,276.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,965,445.67	ADJUSTMENTS	378,776.38
COVERED CHARGES	7,894,536.42	CONTRACTUAL ALLOW	4,002,254.86
NON-COVERED CHARGES	70,909.25	TOTAL MEDICAID LIAB	3,892,281.56
		LESS: COB	15,516.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,876,764.77

TOTAL NUMBER OF ADMISSIONS 931

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,952	0	1,268,750.00	42,782.00
NURSERY CARE CHARGES	212	0	80,560.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,164	0	1,349,310.00	42,782.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	331	0	500,765.00	0.00
N I C U	448	0	416,640.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	779	0	917,405.00	0.00
TOTAL ACCOMODATIONS	2,943	0	2,266,715.00	42,782.00

INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	905,735.94	0.00
MED/SURG SUPPLY	713,305.78	12,654.00
LABORATORY-GENERAL	1,004,334.85	0.00
RADIOLOGY-DIAGNOSTIC	143,189.00	0.00
CT SCAN	341,615.00	0.00
PHYSICAL THERAPY	60,669.00	0.00
EKG/ECG	32,192.00	0.00
IV THERAPY	54,751.00	0.00
OPERATING ROOM	686,586.35	0.00
LABOR/DELIVERY ROOM	314,629.00	0.00
RESPIRATORY SERVICES	227,273.50	0.00
ANESTHESIA	26,466.00	0.00
GI SERVICES	32,118.00	0.00
EMERGENCY ROOM	329,706.50	0.00
RECOVERY ROOM	172,284.00	0.00
LABORATORY PATHOLOGIC	24,665.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,633.00	0.00
SPEECH PATHOLOGY	935.00	0.00
RENAL DIALYSIS	11,770.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	11.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	41,548.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	63,835.00	484.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,531.00	0.00
AUDIOLOGY	25,362.00	0.00
CARDIOLOGY	79,709.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,889.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,892.00	4,621.00
OTHER LAB SERVICES	14,118.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	5,928.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	43,421.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	205,657.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	63.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,366.00

TOTAL ANCILLARY	5,627,821.42	28,127.25
TOTAL ACCOMODATIONS	2,266,715.00	42,782.00
TOTAL CHARGES	7,894,536.42	70,909.25

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,352.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,254.00	CONTRACTUAL ALLOW	19.30-
NON-COVERED CHARGES	98.00	TOTAL MEDICAID LIAB	4,273.30
		LESS: COB	4,273.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	1,300.00	50.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,300.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,300.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	721.25	0.00
MED/SURG SUPPLY	336.25	48.00
LABORATORY-GENERAL	176.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,503.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	217.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,954.00	48.00
TOTAL ACCOMODATIONS	1,300.00	50.00
TOTAL CHARGES	4,254.00	98.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,845,050.71	ADJUSTMENTS	335,110.14
COVERED CHARGES	9,496,729.86	CONTRACTUAL ALLOW	6,781,263.14
NON-COVERED CHARGES	348,320.85	TOTAL MEDICAID LIAB	2,715,466.72
		LESS: COB	1,925.15
		LESS: COPAYMENT	5,151.00
		REIMBURSEMENT	2,708,390.57
		ALL OTHER	2,485,870.17
		FEE SCHEDULE-LAB	203,454.62
		INJECTABLE DRUGS	19,065.78

TOTAL NUMBER OF CLAIMS 8,299

OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	496,871.05	3,987.75
MED/SURG SUPPLY	334,264.32	1,411.50
LABORATORY-GENERAL	0.00	10,614.00
RADIOLOGY-DIAGNOSTIC	518,603.00	2,507.00
CT SCAN	1,128,265.00	42,799.00
PHYSICAL THERAPY	221,477.00	533.00
EKG/ECG	95,369.00	915.00
IV THERAPY	102,139.00	1,918.00
OPERATING ROOM	773,251.76	15,567.00
LABOR/DELIVERY ROOM	312,745.50	0.00
RESPIRATORY SERVICES	81,316.00	18,160.00
ANESTHESIA	39,100.00	0.00
GI SERVICES	72,183.00	3,520.00
EMERGENCY ROOM	2,320,207.50	4,742.00
RECOVERY ROOM	199,002.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	15,912.00	0.00
OCCUPATIONAL THERAPY	24,825.00	0.00
SPEECH PATHOLOGY	2,186.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	47,679.00	213.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	206,764.00	13,814.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,136.00	1,460.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	122,563.00	0.00
AUDIOLOGY	213.00	0.00
CARDIOLOGY	104,690.00	573.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	86,846.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	224,716.00	9,288.00
OTHER LAB SERVICES	58,159.00	156.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	8,429.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,644,492.76	205,120.85
MRI SERVICES	194,681.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,104.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,968.97	2,291.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	301.00

TOTAL ANCILLARY	9,496,729.86	348,320.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,496,729.86	348,320.85

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	32,003.15	ADJUSTMENTS	0.00
COVERED CHARGES	28,337.25	CONTRACTUAL ALLOW	23,978.77
NON-COVERED CHARGES	3,665.90	TOTAL MEDICAID LIAB	4,358.48
		LESS: COB	4,346.48
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	827.04-
		FEE SCHEDULE-LAB	821.38
		INJECTABLE DRUGS	5.66

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	651.75	0.00
MED/SURG SUPPLY	887.75	0.00
LABORATORY-GENERAL	0.00	637.90
RADIOLOGY-DIAGNOSTIC	2,942.00	0.00
CT SCAN	1,281.00	0.00
PHYSICAL THERAPY	1,108.00	0.00
EKG/ECG	414.00	0.00
IV THERAPY	630.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	147.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,690.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	803.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,456.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	875.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,429.00	3,028.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,337.25	3,665.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,337.25	3,665.90

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	511,166.87	ADJUSTMENTS	1,283.14
COVERED CHARGES	505,603.62	CONTRACTUAL ALLOW	452,250.95
NON-COVERED CHARGES	5,563.25	TOTAL MEDICAID LIAB	53,352.67
		LESS: COB	56.32
		LESS: COPAYMENT	1,329.00
		REIMBURSEMENT	51,967.35

TOTAL NUMBER OF CLAIMS 1,067

OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,727.37	79.25
MED/SURG SUPPLY	5,516.50	0.00
LABORATORY-GENERAL	81,904.00	5,471.00
RADIOLOGY-DIAGNOSTIC	24,208.00	0.00
CT SCAN	16,827.00	0.00
PHYSICAL THERAPY	648.00	0.00
EKG/ECG	1,044.00	0.00
IV THERAPY	2,552.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	810.00	0.00
RESPIRATORY SERVICES	4,189.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	333,995.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,280.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,002.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,888.75	13.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	505,603.62	5,563.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	505,603.62	5,563.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,081.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,081.50	CONTRACTUAL ALLOW	438.47
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	643.03
		LESS: COB	643.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100.50	0.00
MED/SURG SUPPLY	60.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	864.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,081.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,081.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	564,703.03	ADJUSTMENTS	36,293.37
COVERED CHARGES	554,290.03	CONTRACTUAL ALLOW	423,828.68
NON-COVERED CHARGES	10,413.00	TOTAL MEDICAID LIAB	130,461.35
		LESS: COB	1,000.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	129,239.35

TOTAL NUMBER OF CLAIMS 38

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP32

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,243.25	0.00
MED/SURG SUPPLY	101,385.70	5.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,264.00	1,928.00
CT SCAN	19,035.00	3,216.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,773.00	0.00
IV THERAPY	7,218.00	0.00
OPERATING ROOM	159,544.85	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49,672.00	0.00
ANESTHESIA	6,850.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,403.00	0.00
RECOVERY ROOM	28,080.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,293.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	864.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	38,498.00	0.00
OTHER IMAGING SERVICES	3,368.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,030.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,836.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,148.00	765.00
OTHER LAB SERVICES	260.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,218.48	4,435.00
MRI SERVICES	3,224.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,081.75	64.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	554,290.03	10,413.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	554,290.03	10,413.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CTR
801 W GORDON
THOMASTON GA 30286-3426

PROVIDER NUMBER 000001988A
NUMBER OF BEDS 119
TITLE XVIII NO: HOSP32

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,635,585.05	ADJUSTMENTS	57,228.30
COVERED CHARGES	5,276,253.94	CONTRACTUAL ALLOW	2,563,609.32
NON-COVERED CHARGES	359,331.11	TOTAL MEDICAID LIAB	2,712,644.62
		LESS: COB	13,010.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,699,634.30

TOTAL NUMBER OF ADMISSIONS 791

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	829	668	369,264.00	320,667.00
NURSERY CARE CHARGES	346	0	91,344.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	459.00
TOTAL ROUTINE	1,175	669	460,608.00	321,126.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	227	0	250,760.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	227	0	250,760.00	0.00
TOTAL ACCOMODATIONS	1,402	669	711,368.00	321,126.00

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,389,372.92	0.00
MED/SURG SUPPLY	795,073.92	0.00
LABORATORY-GENERAL	646,781.80	1,085.82
RADIOLOGY-DIAGNOSTIC	118,409.15	0.00
CT SCAN	162,066.09	4,973.51
PHYSICAL THERAPY	12,456.08	0.00
EKG/ECG	39,938.60	0.00
IV THERAPY	23,973.36	0.00
OPERATING ROOM	293,177.51	0.00
LABOR/DELIVERY ROOM	110,998.40	0.00
RESPIRATORY SERVICES	142,298.29	0.00
ANESTHESIA	194,074.40	0.00
GI SERVICES	29,095.00	0.00
EMERGENCY ROOM	162,303.34	0.00
RECOVERY ROOM	81,373.20	0.00
LABORATORY PATHOLOGIC	10,928.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,632.34	0.00
SPEECH PATHOLOGY	1,484.99	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,307.79	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	72,913.07	5,716.23
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,913.56	0.00
AUDIOLOGY	641.52	8,005.75
CARDIOLOGY	61,234.43	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,898.32	0.00
OTHER LAB SERVICES	51,975.82	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	18,423.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,130.76	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44,433.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,564,885.94	38,205.11
TOTAL ACCOMODATIONS	711,368.00	321,126.00
TOTAL CHARGES	5,276,253.94	359,331.11

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,815.56	ADJUSTMENTS	0.00
COVERED CHARGES	3,797.56	CONTRACTUAL ALLOW	1,147.65
NON-COVERED CHARGES	18.00	TOTAL MEDICAID LIAB	2,649.91
		LESS: COB	2,649.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	0	441.00	18.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	441.00	18.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	441.00	18.00

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,019.81	0.00
MED/SURG SUPPLY	197.36	0.00
LABORATORY-GENERAL	420.09	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	775.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	605.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	206.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	132.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,356.56	0.00
TOTAL ACCOMODATIONS	441.00	18.00
TOTAL CHARGES	3,797.56	18.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,373,192.46	ADJUSTMENTS	56,587.26
COVERED CHARGES	4,870,298.37	CONTRACTUAL ALLOW	2,895,081.62
NON-COVERED CHARGES	502,894.09	TOTAL MEDICAID LIAB	1,975,216.75
		LESS: COB	6,143.17
		LESS: COPAYMENT	7,353.00
		REIMBURSEMENT	1,961,720.58
		ALL OTHER	1,837,060.95
		FEE SCHEDULE-LAB	122,176.34
		INJECTABLE DRUGS	2,483.29

TOTAL NUMBER OF CLAIMS 6,974

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	576,277.34	19,116.66
MED/SURG SUPPLY	303,467.69	2,792.28
LABORATORY-GENERAL	0.00	123,536.71
RADIOLOGY-DIAGNOSTIC	458,209.69	17,147.51
CT SCAN	353,285.76	18,865.43
PHYSICAL THERAPY	67,141.98	7,368.77
EKG/ECG	53,807.00	872.30
IV THERAPY	65,448.42	490.88
OPERATING ROOM	190,594.75	40,385.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46,531.72	688.38
ANESTHESIA	174,152.21	577.50
GI SERVICES	32,336.25	7,407.50
EMERGENCY ROOM	1,001,715.13	45,747.46
RECOVERY ROOM	155,941.08	572.83
LABORATORY PATHOLOGIC	0.00	63.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,687.96	4,360.34
SPEECH PATHOLOGY	53,094.41	3,523.37
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	948.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	130,152.75	8,925.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	682.50	5,981.48
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,075.15	4,533.21
AUDIOLOGY	410.24	197.95
CARDIOLOGY	34,618.02	789.80
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	150,747.94	13,753.30
OTHER LAB SERVICES	120,412.91	858.22
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,727.30	0.00
OTHER THERAPEUTIC SERVI	88.00	18,506.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	739,146.55	143,119.78
MRI SERVICES	85,417.87	1,790.92

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	902.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,179.00	4,491.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,169.14

TOTAL ANCILLARY	4,870,298.37	500,536.09
TOTAL ACCOMODATIONS	0.00	2,358.00
TOTAL CHARGES	4,870,298.37	502,894.09

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	50,029.21	ADJUSTMENTS	0.00
COVERED CHARGES	46,238.77	CONTRACTUAL ALLOW	20,362.76
NON-COVERED CHARGES	3,790.44	TOTAL MEDICAID LIAB	25,876.01
		LESS: COB	25,819.01
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,712.69-
		FEE SCHEDULE-LAB	1,712.69
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,834.89	9.12
MED/SURG SUPPLY	1,474.80	2.20
LABORATORY-GENERAL	0.00	1,549.27
RADIOLOGY-DIAGNOSTIC	5,186.63	0.00
CT SCAN	4,675.86	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	586.30	0.00
IV THERAPY	1,476.64	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	203.28	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,474.85	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	429.01	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,166.52	0.00
OTHER LAB SERVICES	1,304.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,197.83	2,229.85
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	228.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,238.77	3,790.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,238.77	3,790.44

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	421,702.29	ADJUSTMENTS	597.00
COVERED CHARGES	396,780.57	CONTRACTUAL ALLOW	341,004.39
NON-COVERED CHARGES	24,921.72	TOTAL MEDICAID LIAB	55,776.18
		LESS: COB	13.54
		LESS: COPAYMENT	1,050.00
		REIMBURSEMENT	54,712.64

TOTAL NUMBER OF CLAIMS 1,140

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,026.41	0.00
MED/SURG SUPPLY	9,781.64	0.00
LABORATORY-GENERAL	49,428.06	16,099.11
RADIOLOGY-DIAGNOSTIC	30,562.41	756.76
CT SCAN	16,696.99	0.00
PHYSICAL THERAPY	0.00	357.50
EKG/ECG	8,177.65	0.00
IV THERAPY	6,661.96	0.00
OPERATING ROOM	0.00	1,166.55
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,334.96	0.00
ANESTHESIA	462.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	206,244.57	4,908.74
RECOVERY ROOM	381.15	0.00
LABORATORY PATHOLOGIC	58.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,197.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,457.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,442.96	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,596.34	0.00
OTHER LAB SERVICES	1,562.01	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18.44	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,146.77	175.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	396,780.57	24,921.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	396,780.57	24,921.72

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,525.64	ADJUSTMENTS	0.00
COVERED CHARGES	4,328.05	CONTRACTUAL ALLOW	2,388.97
NON-COVERED CHARGES	197.59	TOTAL MEDICAID LIAB	1,939.08
		LESS: COB	1,936.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	677.99	0.00
MED/SURG SUPPLY	308.41	0.00
LABORATORY-GENERAL	618.86	197.59
RADIOLOGY-DIAGNOSTIC	158.18	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	150.15	0.00
IV THERAPY	364.38	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,050.08	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,328.05	197.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,328.05	197.59

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	199,908.29	ADJUSTMENTS	4,003.84
COVERED CHARGES	189,555.36	CONTRACTUAL ALLOW	129,452.76
NON-COVERED CHARGES	10,352.93	TOTAL MEDICAID LIAB	60,102.60
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	60,081.60

TOTAL NUMBER OF CLAIMS 15

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,564.01	2,003.31
MED/SURG SUPPLY	34,499.83	692.80
LABORATORY-GENERAL	0.00	813.67
RADIOLOGY-DIAGNOSTIC	2,250.75	1,168.64
CT SCAN	5,537.57	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	600.60	0.00
IV THERAPY	1,765.26	0.00
OPERATING ROOM	29,109.27	2,542.52
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	22,629.87	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,563.62	274.89
RECOVERY ROOM	8,717.44	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	24,840.20	0.00
OTHER IMAGING SERVICES	1,462.61	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,514.23	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,439.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,795.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,060.30	1,061.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	189,555.36	10,352.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	189,555.36	10,352.93

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 09/16/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,940,461.67	ADJUSTMENTS	124,555.43
COVERED CHARGES	5,651,378.61	CONTRACTUAL ALLOW	2,947,418.41
NON-COVERED CHARGES	289,083.06	TOTAL MEDICAID LIAB	2,703,960.20
		LESS: COB	19,847.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,684,112.27

TOTAL NUMBER OF ADMISSIONS 813

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	961	542	440,709.00	253,174.00
NURSERY CARE CHARGES	356	0	93,984.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,317	542	534,693.00	253,174.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	266	0	281,278.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	266	0	281,278.00	0.00
TOTAL ACCOMODATIONS	1,583	542	815,971.00	253,174.00

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,493,463.89	0.00
MED/SURG SUPPLY	419,624.23	0.00
LABORATORY-GENERAL	743,009.36	1,244.20
RADIOLOGY-DIAGNOSTIC	128,226.15	0.00
CT SCAN	266,736.33	0.00
PHYSICAL THERAPY	26,289.31	0.00
EKG/ECG	38,784.46	0.00
IV THERAPY	19,595.32	0.00
OPERATING ROOM	396,370.47	0.00
LABOR/DELIVERY ROOM	123,806.30	0.00
RESPIRATORY SERVICES	119,160.39	0.00
ANESTHESIA	229,018.97	0.00
GI SERVICES	28,799.99	0.00
EMERGENCY ROOM	221,311.27	0.00
RECOVERY ROOM	94,170.13	0.00
LABORATORY PATHOLOGIC	12,659.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,355.81	0.00
SPEECH PATHOLOGY	639.04	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	51,646.62	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,144.67	1,885.68
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	48,543.89	0.00
AUDIOLOGY	182.94	8,764.42
CARDIOLOGY	105,276.77	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,960.02	0.00
OTHER LAB SERVICES	92,325.76	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	24,014.76
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	19,709.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	101,596.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,835,407.61	35,909.06
TOTAL ACCOMODATIONS	815,971.00	253,174.00
TOTAL CHARGES	5,651,378.61	289,083.06

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,973.04	ADJUSTMENTS	0.00
COVERED CHARGES	13,973.04	CONTRACTUAL ALLOW	4,385.85
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	9,587.19
		LESS: COB	9,587.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4	0	1,836.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,836.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,836.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,690.22	0.00
MED/SURG SUPPLY	936.94	0.00
LABORATORY-GENERAL	1,591.47	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,424.50	0.00
LABOR/DELIVERY ROOM	1,791.42	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	947.11	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	477.02	0.00
LABORATORY PATHOLOGIC	61.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	217.14	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,137.04	0.00
TOTAL ACCOMODATIONS	1,836.00	0.00
TOTAL CHARGES	13,973.04	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,871,809.51	ADJUSTMENTS	202,683.05
COVERED CHARGES	6,408,429.48	CONTRACTUAL ALLOW	4,049,928.89
NON-COVERED CHARGES	463,380.03	TOTAL MEDICAID LIAB	2,358,500.59
		LESS: COB	2,131.92
		LESS: COPAYMENT	3,822.00
		REIMBURSEMENT	2,352,546.67
		ALL OTHER	2,214,277.79
		FEE SCHEDULE-LAB	138,268.88
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7,532

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	565,585.32	25,197.17
MED/SURG SUPPLY	245,591.79	2,128.54
LABORATORY-GENERAL	2,233.98	60,925.12
RADIOLOGY-DIAGNOSTIC	472,594.75	7,160.65
CT SCAN	693,952.23	35,133.50
PHYSICAL THERAPY	97,388.37	3,568.62
EKG/ECG	65,136.46	480.49
IV THERAPY	186,638.66	399.58
OPERATING ROOM	240,414.23	24,571.07
LABOR/DELIVERY ROOM	895.71	0.00
RESPIRATORY SERVICES	35,985.31	0.00
ANESTHESIA	200,046.65	2,102.11
GI SERVICES	38,207.48	1,270.50
EMERGENCY ROOM	1,507,596.61	2,329.51
RECOVERY ROOM	182,268.45	2,490.34
LABORATORY PATHOLOGIC	0.00	92.72
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,905.11	4,631.23
SPEECH PATHOLOGY	14,234.66	467.27
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,142.53	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	164,006.16	8,541.62
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,354.50	5,518.51
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	76,524.21	3,189.15
AUDIOLOGY	232.84	0.00
CARDIOLOGY	57,410.69	912.22
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	291,372.56	10,447.81
OTHER LAB SERVICES	202,543.01	57.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,829.29	0.00
OTHER THERAPEUTIC SERVI	0.00	22,257.32
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	928,315.92	224,578.39
MRI SERVICES	113,648.20	1,604.53

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	975.26
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	5,236.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	373.80	2,856.04

TOTAL ANCILLARY	6,408,429.48	459,123.03
TOTAL ACCOMODATIONS	0.00	4,257.00
TOTAL CHARGES	6,408,429.48	463,380.03

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	50,872.50	ADJUSTMENTS	0.00
COVERED CHARGES	46,800.74	CONTRACTUAL ALLOW	17,564.48
NON-COVERED CHARGES	4,071.76	TOTAL MEDICAID LIAB	29,236.26
		LESS: COB	29,212.26
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	749.63-
		FEE SCHEDULE-LAB	749.63
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 57

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,767.82	0.00
MED/SURG SUPPLY	2,275.91	2.31
LABORATORY-GENERAL	0.00	421.30
RADIOLOGY-DIAGNOSTIC	3,091.49	158.18
CT SCAN	5,129.15	0.00
PHYSICAL THERAPY	347.93	0.00
EKG/ECG	630.64	0.00
IV THERAPY	804.58	0.00
OPERATING ROOM	2,780.97	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	212.52	0.00
ANESTHESIA	2,001.04	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,692.56	798.16
RECOVERY ROOM	1,887.98	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	785.37	583.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	362.37	0.00
OTHER LAB SERVICES	340.49	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	101.64	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,983.75	2,108.71
MRI SERVICES	1,604.53	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,800.74	4,071.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,800.74	4,071.76

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	355,134.94	ADJUSTMENTS	2,299.00
COVERED CHARGES	344,759.13	CONTRACTUAL ALLOW	297,199.08
NON-COVERED CHARGES	10,375.81	TOTAL MEDICAID LIAB	47,560.05
		LESS: COB	26.05
		LESS: COPAYMENT	1,011.00
		REIMBURSEMENT	46,523.00

TOTAL NUMBER OF CLAIMS 949

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,971.03	0.00
MED/SURG SUPPLY	7,964.03	0.00
LABORATORY-GENERAL	37,543.39	8,547.87
RADIOLOGY-DIAGNOSTIC	25,216.89	0.00
CT SCAN	12,130.05	1,457.93
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,393.47	0.00
IV THERAPY	3,477.96	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,254.52	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	210,994.94	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	92.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,124.28	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,765.65	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,396.24	0.00
OTHER LAB SERVICES	1,498.54	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	935.64	153.74
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	216.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	344,759.13	10,375.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	344,759.13	10,375.81

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,466.18	ADJUSTMENTS	0.00
COVERED CHARGES	2,305.59	CONTRACTUAL ALLOW	1,492.79
NON-COVERED CHARGES	160.59	TOTAL MEDICAID LIAB	812.80
		LESS: COB	809.80
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221.21	0.00
MED/SURG SUPPLY	160.88	0.00
LABORATORY-GENERAL	603.34	160.59
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	144.38	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,175.78	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,305.59	160.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,305.59	160.59

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	704,433.08	ADJUSTMENTS	31,462.74
COVERED CHARGES	665,551.16	CONTRACTUAL ALLOW	474,661.82
NON-COVERED CHARGES	38,881.92	TOTAL MEDICAID LIAB	190,889.34
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	190,784.34

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,636.52	2,412.93
MED/SURG SUPPLY	80,479.84	8,738.73
LABORATORY-GENERAL	260.52	532.25
RADIOLOGY-DIAGNOSTIC	8,995.23	264.26
CT SCAN	7,476.68	0.00
PHYSICAL THERAPY	1,365.95	194.39
EKG/ECG	3,528.60	0.00
IV THERAPY	12,072.62	0.00
OPERATING ROOM	112,220.75	2,597.24
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,442.36	0.00
ANESTHESIA	84,260.78	0.00
GI SERVICES	3,003.00	0.00
EMERGENCY ROOM	12,387.75	0.00
RECOVERY ROOM	40,562.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	223.61	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	109,545.32	0.00
OTHER IMAGING SERVICES	3,216.01	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,068.46
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,693.66	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	23,995.68	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,015.30	0.00
OTHER LAB SERVICES	13,643.02	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	9,988.44
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,525.46	11,455.52
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,629.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	665,551.16	38,881.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	665,551.16	38,881.92

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,988,608.57	ADJUSTMENTS	192,925.34
COVERED CHARGES	5,653,023.43	CONTRACTUAL ALLOW	3,216,221.94
NON-COVERED CHARGES	335,585.14	TOTAL MEDICAID LIAB	2,436,801.49
		LESS: COB	25,813.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,410,987.66

TOTAL NUMBER OF ADMISSIONS 629

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	779	636	357,561.00	291,924.00
NURSERY CARE CHARGES	252	0	66,528.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,031	636	424,089.00	291,924.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	226	0	238,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	226	0	238,200.00	0.00
TOTAL ACCOMODATIONS	1,257	636	662,289.00	291,924.00

INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,483,794.50	0.00
MED/SURG SUPPLY	431,732.95	0.00
LABORATORY-GENERAL	759,023.60	1,618.39
RADIOLOGY-DIAGNOSTIC	131,700.55	0.00
CT SCAN	348,961.95	0.00
PHYSICAL THERAPY	15,391.20	0.00
EKG/ECG	44,545.22	0.00
IV THERAPY	15,987.59	0.00
OPERATING ROOM	493,705.17	0.00
LABOR/DELIVERY ROOM	92,960.30	0.00
RESPIRATORY SERVICES	118,035.02	0.00
ANESTHESIA	283,027.74	0.00
GI SERVICES	28,541.86	0.00
EMERGENCY ROOM	203,490.22	0.00
RECOVERY ROOM	121,293.49	0.00
LABORATORY PATHOLOGIC	14,902.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,480.04	0.00
SPEECH PATHOLOGY	603.63	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	38,438.14	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	30,578.50	422.53
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,518.36	0.00
AUDIOLOGY	189.04	4,363.32
CARDIOLOGY	95,898.16	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,339.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	952.84	0.00
OTHER LAB SERVICES	84,937.69	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	22,895.94
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	20,849.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89,854.91	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	14,360.96

TOTAL ANCILLARY	4,990,734.43	43,661.14
TOTAL ACCOMODATIONS	662,289.00	291,924.00
TOTAL CHARGES	5,653,023.43	335,585.14

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,922.39	ADJUSTMENTS	0.00
COVERED CHARGES	8,922.39	CONTRACTUAL ALLOW	3,712.46
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	5,209.93
		LESS: COB	5,209.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5	0	2,295.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	2,295.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	2,295.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,414.40	0.00
MED/SURG SUPPLY	427.23	0.00
LABORATORY-GENERAL	1,523.02	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	985.28	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	108.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	169.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,627.39	0.00
TOTAL ACCOMODATIONS	2,295.00	0.00
TOTAL CHARGES	8,922.39	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,368,234.83	ADJUSTMENTS	75,847.84
COVERED CHARGES	5,765,933.91	CONTRACTUAL ALLOW	3,895,339.16
NON-COVERED CHARGES	602,300.92	TOTAL MEDICAID LIAB	1,870,594.75
		LESS: COB	2,367.16
		LESS: COPAYMENT	3,555.00
		REIMBURSEMENT	1,864,672.59
		ALL OTHER	1,739,530.41
		FEE SCHEDULE-LAB	125,142.18
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,539

OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480,844.88	12,377.56
MED/SURG SUPPLY	193,707.90	6,458.96
LABORATORY-GENERAL	524.56	20,490.26
RADIOLOGY-DIAGNOSTIC	378,611.54	2,350.85
CT SCAN	744,752.18	115,100.01
PHYSICAL THERAPY	42,127.40	7,246.81
EKG/ECG	67,203.46	181.69
IV THERAPY	147,314.73	37,736.66
OPERATING ROOM	202,414.02	16,105.79
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33,607.15	60.98
ANESTHESIA	148,023.49	3,506.59
GI SERVICES	38,372.39	2,541.01
EMERGENCY ROOM	1,405,415.77	38,274.09
RECOVERY ROOM	125,026.36	634.91
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,774.85	2,580.85
SPEECH PATHOLOGY	0.00	542.51
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	69.88	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	117,476.08	785.37
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	719.96	7,789.24
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	75,442.91	0.00
AUDIOLOGY	60.98	0.00
CARDIOLOGY	58,895.06	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,800.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	201,472.91	88,313.49
OTHER LAB SERVICES	169,552.71	11,857.35
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	574.31	0.00
OTHER THERAPEUTIC SERVI	0.00	18,851.88
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	943,403.18	161,611.94
MRI SERVICES	159,744.45	6,070.36

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	33,526.81
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,864.95

TOTAL ANCILLARY	5,765,933.91	600,860.92
TOTAL ACCOMODATIONS	0.00	1,440.00
TOTAL CHARGES	5,765,933.91	602,300.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	50,597.44	ADJUSTMENTS	0.00
COVERED CHARGES	48,126.55	CONTRACTUAL ALLOW	23,567.27
NON-COVERED CHARGES	2,470.89	TOTAL MEDICAID LIAB	24,559.28
		LESS: COB	24,535.28
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	907.69-
		FEE SCHEDULE-LAB	907.69
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,452.38	41.55
MED/SURG SUPPLY	983.10	0.00
LABORATORY-GENERAL	0.00	38.00
RADIOLOGY-DIAGNOSTIC	5,997.80	174.00
CT SCAN	9,395.57	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,024.06	0.00
IV THERAPY	709.94	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	329.05	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,153.74	213.44
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	182.24	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	561.44	0.00
OTHER LAB SERVICES	2,155.57	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,181.66	1,845.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	158.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	48,126.55	2,470.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,126.55	2,470.89

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	443,598.89	ADJUSTMENTS	2,105.02
COVERED CHARGES	431,752.58	CONTRACTUAL ALLOW	379,067.49
NON-COVERED CHARGES	11,846.31	TOTAL MEDICAID LIAB	52,685.09
		LESS: COB	13.50
		LESS: COPAYMENT	1,188.00
		REIMBURSEMENT	51,483.59

TOTAL NUMBER OF CLAIMS 1,045

OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,816.31	641.43
MED/SURG SUPPLY	9,996.22	6.93
LABORATORY-GENERAL	45,795.40	6,517.33
RADIOLOGY-DIAGNOSTIC	24,412.53	0.00
CT SCAN	31,173.67	1,603.72
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,600.73	0.00
IV THERAPY	3,324.22	589.12
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,273.53	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	260,810.49	315.08
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,825.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,417.03	578.54
OTHER LAB SERVICES	3,932.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,373.62	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,594.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	431,752.58	11,846.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	431,752.58	11,846.31

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,269.47	ADJUSTMENTS	0.00
COVERED CHARGES	3,922.89	CONTRACTUAL ALLOW	2,730.50
NON-COVERED CHARGES	346.58	TOTAL MEDICAID LIAB	1,192.39
		LESS: COB	1,189.39
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	238.90	0.00
MED/SURG SUPPLY	71.96	0.00
LABORATORY-GENERAL	1,230.22	20.00
RADIOLOGY-DIAGNOSTIC	174.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,207.81	326.58
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,922.89	346.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,922.89	346.58

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	650,676.04	ADJUSTMENTS	17,146.30
COVERED CHARGES	598,069.60	CONTRACTUAL ALLOW	440,296.04
NON-COVERED CHARGES	52,606.44	TOTAL MEDICAID LIAB	157,773.56
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	157,617.56

TOTAL NUMBER OF CLAIMS 46

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 20BBFLD

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,860.29	921.04
MED/SURG SUPPLY	86,350.50	286.22
LABORATORY-GENERAL	0.00	1,154.56
RADIOLOGY-DIAGNOSTIC	7,126.79	0.00
CT SCAN	23,864.24	6,283.94
PHYSICAL THERAPY	0.00	304.68
EKG/ECG	3,617.25	0.00
IV THERAPY	19,384.32	410.08
OPERATING ROOM	106,214.42	18,059.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,729.96	0.00
ANESTHESIA	78,863.22	0.00
GI SERVICES	1,397.55	0.00
EMERGENCY ROOM	14,752.29	701.31
RECOVERY ROOM	32,421.12	0.00
LABORATORY PATHOLOGIC	0.00	85.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	47,339.22	0.00
OTHER IMAGING SERVICES	3,523.34	658.94
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,085.88	2,080.05
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,274.52	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	33,841.54	3,462.57
OTHER LAB SERVICES	14,172.39	1,944.96
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	6,525.12
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36,250.76	7,510.03
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	802.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,415.20

TOTAL ANCILLARY	598,069.60	52,606.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	598,069.60	52,606.44

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE, HMA INC
330 ALCOVY STREET
MONROE GA 30655-2140

PROVIDER NUMBER 000020677A
NUMBER OF BEDS 77
TITLE XVIII NO: 20BBFLD

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	646,318.16	ADJUSTMENTS	5,747.32
COVERED CHARGES	605,848.84	CONTRACTUAL ALLOW	213,750.18
NON-COVERED CHARGES	40,469.32	TOTAL MEDICAID LIAB	392,098.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	392,098.66

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	281	0	73,300.00	15,030.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	281	0	73,300.00	15,030.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	281	0	73,300.00	15,030.00

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,983.29	0.00
MED/SURG SUPPLY	90,239.97	75.10
LABORATORY-GENERAL	69,810.40	38.00
RADIOLOGY-DIAGNOSTIC	10,741.00	0.00
CT SCAN	11,951.70	0.00
PHYSICAL THERAPY	588.40	0.00
EKG/ECG	8,580.00	0.00
IV THERAPY	2,150.00	0.00
OPERATING ROOM	45,300.00	0.00
LABOR/DELIVERY ROOM	28,423.00	0.00
RESPIRATORY SERVICES	19,085.70	0.00
ANESTHESIA	15,500.00	0.00
GI SERVICES	9,245.70	0.00
EMERGENCY ROOM	10,450.00	0.00
RECOVERY ROOM	20,400.00	0.00
LABORATORY PATHOLOGIC	1,940.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	353.60	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,207.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,879.00	5,679.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,999.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	42,262.39	0.00
OTHER LAB SERVICES	1,538.05	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	428.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,508.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	16,410.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	2,500.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,411.54	309.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	532,548.84	25,439.32
TOTAL ACCOMODATIONS	73,300.00	15,030.00
TOTAL CHARGES	605,848.84	40,469.32

ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,908.58	ADJUSTMENTS	0.00
COVERED CHARGES	12,808.58	CONTRACTUAL ALLOW	900.00
NON-COVERED CHARGES	100.00	TOTAL MEDICAID LIAB	11,908.58
		LESS: COB	11,908.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5	0	1,300.00	100.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	1,300.00	100.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	1,300.00	100.00

ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,707.58	0.00
MED/SURG SUPPLY	1,060.95	0.00
LABORATORY-GENERAL	2,240.00	0.00
RADIOLOGY-DIAGNOSTIC	547.85	0.00
CT SCAN	963.70	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	220.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	879.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	330.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	559.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,508.58	0.00
TOTAL ACCOMODATIONS	1,300.00	100.00
TOTAL CHARGES	12,808.58	100.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	871,300.95	ADJUSTMENTS	3,628.01
COVERED CHARGES	782,031.25	CONTRACTUAL ALLOW	250,301.39
NON-COVERED CHARGES	89,269.70	TOTAL MEDICAID LIAB	531,729.86
		LESS: COB	2,580.54
		LESS: COPAYMENT	408.00
		REIMBURSEMENT	528,741.32
		ALL OTHER	503,354.18
		FEE SCHEDULE-LAB	25,387.14
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,480

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,716.62	2,499.45
MED/SURG SUPPLY	39,744.89	3,870.32
LABORATORY-GENERAL	326.00	10,725.90
RADIOLOGY-DIAGNOSTIC	64,828.15	6,166.45
CT SCAN	80,367.45	0.00
PHYSICAL THERAPY	948.30	2,001.95
EKG/ECG	21,340.00	440.00
IV THERAPY	4,350.00	0.00
OPERATING ROOM	5,800.00	0.00
LABOR/DELIVERY ROOM	14,279.50	0.00
RESPIRATORY SERVICES	3,336.50	48.00
ANESTHESIA	5,580.00	1,750.00
GI SERVICES	32,338.50	5,800.00
EMERGENCY ROOM	138,085.00	1,245.00
RECOVERY ROOM	34,800.00	1,200.00
LABORATORY PATHOLOGIC	0.00	1,197.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	752.45	672.45
SPEECH PATHOLOGY	1,957.03	1,026.40
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,776.50	1,203.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,148.00	1,262.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,761.90	999.60
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,200.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,699.65	7,043.18
OTHER LAB SERVICES	4,895.40	96.00
RECREATIONAL THERAPY	164.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,674.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	165,628.46	34,968.30
MRI SERVICES	13,798.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,460.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	310.00	140.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	98.70	0.00

TOTAL ANCILLARY	782,031.25	88,489.70
TOTAL ACCOMODATIONS	0.00	780.00
TOTAL CHARGES	782,031.25	89,269.70

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,879.61	ADJUSTMENTS	0.00
COVERED CHARGES	10,387.30	CONTRACTUAL ALLOW	3,960.46
NON-COVERED CHARGES	1,492.31	TOTAL MEDICAID LIAB	6,426.84
		LESS: COB	6,426.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	341.59-
		FEE SCHEDULE-LAB	341.59
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	443.21	137.76
MED/SURG SUPPLY	513.58	0.00
LABORATORY-GENERAL	0.00	63.00
RADIOLOGY-DIAGNOSTIC	490.55	112.55
CT SCAN	2,669.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	440.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,013.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,220.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	403.56	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	164.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	82.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,029.00	1,097.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,387.30	1,492.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,387.30	1,492.31

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	53,631.45	ADJUSTMENTS	197.00
COVERED CHARGES	51,144.50	CONTRACTUAL ALLOW	39,994.50
NON-COVERED CHARGES	2,486.95	TOTAL MEDICAID LIAB	11,150.00
		LESS: COB	1.31
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	10,884.69

TOTAL NUMBER OF CLAIMS 223

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,720.32	0.00
MED/SURG SUPPLY	600.18	263.90
LABORATORY-GENERAL	8,528.00	1,814.00
RADIOLOGY-DIAGNOSTIC	3,587.45	259.05
CT SCAN	3,702.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,100.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	449.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,120.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	304.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	51,144.50	2,486.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,144.50	2,486.95

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	297.95	ADJUSTMENTS	0.00
COVERED CHARGES	120.95	CONTRACTUAL ALLOW	120.95
NON-COVERED CHARGES	177.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120.95	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	57.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	120.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	120.95	177.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	120.95	177.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET

WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	112,666.51	ADJUSTMENTS	4,707.22
COVERED CHARGES	101,966.94	CONTRACTUAL ALLOW	40,773.08
NON-COVERED CHARGES	10,699.57	TOTAL MEDICAID LIAB	61,193.86
		LESS: COB	3,000.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	58,187.86

TOTAL NUMBER OF CLAIMS 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,825.17	122.60
MED/SURG SUPPLY	25,984.58	0.00
LABORATORY-GENERAL	0.00	271.00
RADIOLOGY-DIAGNOSTIC	1,075.45	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,320.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	21,650.00	2,550.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	85.00	0.00
ANESTHESIA	7,000.00	0.00
GI SERVICES	4,300.00	1,300.00
EMERGENCY ROOM	1,430.00	0.00
RECOVERY ROOM	16,800.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	918.30	240.70
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	287.00	631.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	731.44	1,161.27
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,560.00	923.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,500.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	101,966.94	10,699.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	101,966.94	10,699.57

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 07/18/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	525,346.10	ADJUSTMENTS	4,967.77
COVERED CHARGES	478,009.98	CONTRACTUAL ALLOW	179,410.02
NON-COVERED CHARGES	47,336.12	TOTAL MEDICAID LIAB	298,599.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	298,599.96

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	218	0	61,040.00	39,910.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	218	0	61,040.00	39,910.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	218	0	61,040.00	39,910.00

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,631.32	0.00
MED/SURG SUPPLY	55,156.85	0.00
LABORATORY-GENERAL	51,294.30	0.00
RADIOLOGY-DIAGNOSTIC	8,436.60	0.00
CT SCAN	25,727.75	0.00
PHYSICAL THERAPY	1,603.75	0.00
EKG/ECG	6,600.00	0.00
IV THERAPY	9,000.00	0.00
OPERATING ROOM	10,600.00	0.00
LABOR/DELIVERY ROOM	49,490.00	0.00
RESPIRATORY SERVICES	7,693.50	0.00
ANESTHESIA	30,041.00	0.00
GI SERVICES	5,800.00	0.00
EMERGENCY ROOM	10,650.00	0.00
RECOVERY ROOM	14,400.00	0.00
LABORATORY PATHOLOGIC	1,688.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,476.25	0.00
SPEECH PATHOLOGY	1,272.45	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,484.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,722.00	2,524.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,169.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	32,016.10	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	4,166.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,005.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	35.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,010.51	701.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	416,969.98	7,426.12
TOTAL ACCOMODATIONS	61,040.00	39,910.00
TOTAL CHARGES	478,009.98	47,336.12

ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	809,882.84	ADJUSTMENTS	6,599.94
COVERED CHARGES	717,481.36	CONTRACTUAL ALLOW	345,752.51
NON-COVERED CHARGES	92,401.48	TOTAL MEDICAID LIAB	371,728.85
		LESS: COB	616.46
		LESS: COPAYMENT	987.00
		REIMBURSEMENT	370,125.39
		ALL OTHER	345,140.65
		FEE SCHEDULE-LAB	21,829.55
		INJECTABLE DRUGS	3,155.19

TOTAL NUMBER OF CLAIMS 1,265

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,949.55	1,447.61
MED/SURG SUPPLY	41,229.40	1,879.25
LABORATORY-GENERAL	978.00	10,219.00
RADIOLOGY-DIAGNOSTIC	53,456.25	4,036.60
CT SCAN	60,555.35	0.00
PHYSICAL THERAPY	2,944.35	2,742.62
EKG/ECG	14,960.00	0.00
IV THERAPY	26,250.00	500.00
OPERATING ROOM	10,614.00	1,935.00
LABOR/DELIVERY ROOM	3,430.00	0.00
RESPIRATORY SERVICES	2,890.40	0.00
ANESTHESIA	11,441.00	15,715.00
GI SERVICES	21,177.65	0.00
EMERGENCY ROOM	148,775.00	150.00
RECOVERY ROOM	34,200.00	0.00
LABORATORY PATHOLOGIC	0.00	1,326.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,556.25	1,791.30
SPEECH PATHOLOGY	3,889.33	2,116.90
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	26,773.50	1,200.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	861.00	1,262.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,149.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,350.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,604.35	7,042.95
OTHER LAB SERVICES	3,919.60	0.00
RECREATIONAL THERAPY	592.00	300.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	17,642.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	132,072.25	17,968.00
MRI SERVICES	21,585.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,140.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,277.63	27.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	717,481.36	91,441.48
TOTAL ACCOMODATIONS	0.00	960.00
TOTAL CHARGES	717,481.36	92,401.48

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,645.70	ADJUSTMENTS	0.00
COVERED CHARGES	12,942.70	CONTRACTUAL ALLOW	4,239.43
NON-COVERED CHARGES	703.00	TOTAL MEDICAID LIAB	8,703.27
		LESS: COB	8,694.27
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	104.44-
		FEE SCHEDULE-LAB	95.14
		INJECTABLE DRUGS	9.30

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227.96	0.00
MED/SURG SUPPLY	229.31	0.00
LABORATORY-GENERAL	0.00	18.00
RADIOLOGY-DIAGNOSTIC	581.75	0.00
CT SCAN	2,623.05	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	440.00	0.00
IV THERAPY	500.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,125.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	75.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,800.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	50.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	766.00	185.00
MRI SERVICES	4,508.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	500.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.58	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,942.70	703.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,942.70	703.00

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	42,493.37	ADJUSTMENTS	197.00
COVERED CHARGES	39,982.32	CONTRACTUAL ALLOW	32,832.32
NON-COVERED CHARGES	2,511.05	TOTAL MEDICAID LIAB	7,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	7,099.00

TOTAL NUMBER OF CLAIMS 143

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,889.22	11.50
MED/SURG SUPPLY	380.25	119.85
LABORATORY-GENERAL	4,871.00	419.00
RADIOLOGY-DIAGNOSTIC	3,102.25	275.80
CT SCAN	5,954.55	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	660.00	0.00
IV THERAPY	1,000.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,400.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	400.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	325.05	0.00
RECREATIONAL THERAPY	0.00	350.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,314.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	20.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	39,982.32	2,511.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,982.32	2,511.05

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	335.80	ADJUSTMENTS	0.00
COVERED CHARGES	335.80	CONTRACTUAL ALLOW	203.90
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	131.90
		LESS: COB	128.90
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.65	0.00
MED/SURG SUPPLY	19.15	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	250.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	335.80	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	335.80	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET

WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	46,857.55	ADJUSTMENTS	0.00
COVERED CHARGES	41,034.08	CONTRACTUAL ALLOW	22,205.20
NON-COVERED CHARGES	5,823.47	TOTAL MEDICAID LIAB	18,828.88
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	18,822.88

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,397.87	581.47
MED/SURG SUPPLY	8,839.43	0.00
LABORATORY-GENERAL	326.00	81.00
RADIOLOGY-DIAGNOSTIC	898.70	0.00
CT SCAN	1,715.45	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	440.00	0.00
IV THERAPY	1,000.00	0.00
OPERATING ROOM	4,951.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	660.80	0.00
ANESTHESIA	1,533.00	4,000.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,050.00	0.00
RECOVERY ROOM	8,400.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	304.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	999.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,035.23	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	246.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,482.10	915.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	41,034.08	5,823.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,034.08	5,823.47

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 07/19/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	699,444.21	ADJUSTMENTS	13,017.01
COVERED CHARGES	646,633.64	CONTRACTUAL ALLOW	232,135.93
NON-COVERED CHARGES	52,810.57	TOTAL MEDICAID LIAB	414,497.71
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	414,497.71

TOTAL NUMBER OF ADMISSIONS 97

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	329	0	112,860.00	38,340.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	329	0	112,860.00	38,340.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	329	0	112,860.00	38,340.00

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,008.78	0.00
MED/SURG SUPPLY	59,745.65	0.00
LABORATORY-GENERAL	87,648.67	0.00
RADIOLOGY-DIAGNOSTIC	13,417.75	0.00
CT SCAN	28,235.70	0.00
PHYSICAL THERAPY	6,190.70	0.00
EKG/ECG	12,540.00	0.00
IV THERAPY	6,250.00	0.00
OPERATING ROOM	5,336.00	0.00
LABOR/DELIVERY ROOM	48,100.00	0.00
RESPIRATORY SERVICES	14,227.70	0.00
ANESTHESIA	12,073.00	0.00
GI SERVICES	3,900.00	0.00
EMERGENCY ROOM	17,816.00	0.00
RECOVERY ROOM	10,800.00	0.00
LABORATORY PATHOLOGIC	343.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,360.05	0.00
SPEECH PATHOLOGY	3,894.87	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,533.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,338.00	4,178.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,768.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46,076.60	0.00
OTHER LAB SERVICES	5,822.40	0.00
RECREATIONAL THERAPY	952.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,864.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,279.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,175.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	253.57
INJECTABLE DRUGS	27,116.17	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	533,773.64	14,470.57
TOTAL ACCOMODATIONS	112,860.00	38,340.00
TOTAL CHARGES	646,633.64	52,810.57

ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,380,107.47	ADJUSTMENTS	27,840.17
COVERED CHARGES	1,210,718.40	CONTRACTUAL ALLOW	556,619.58
NON-COVERED CHARGES	169,389.07	TOTAL MEDICAID LIAB	654,098.82
		LESS: COB	1,735.97
		LESS: COPAYMENT	1,005.00
		REIMBURSEMENT	651,357.85
		ALL OTHER	609,509.65
		FEE SCHEDULE-LAB	30,529.97
		INJECTABLE DRUGS	11,318.23

TOTAL NUMBER OF CLAIMS 2,232

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,674.73	6,716.34
MED/SURG SUPPLY	51,209.27	10,043.94
LABORATORY-GENERAL	2,394.00	18,868.00
RADIOLOGY-DIAGNOSTIC	91,649.30	3,339.95
CT SCAN	122,659.60	0.00
PHYSICAL THERAPY	471.98	893.25
EKG/ECG	23,980.00	440.00
IV THERAPY	21,300.00	850.00
OPERATING ROOM	5,062.00	5,986.00
LABOR/DELIVERY ROOM	3,600.00	0.00
RESPIRATORY SERVICES	6,067.90	181.00
ANESTHESIA	13,455.00	6,000.00
GI SERVICES	38,164.60	1,536.95
EMERGENCY ROOM	328,599.00	12,646.00
RECOVERY ROOM	43,800.00	1,500.00
LABORATORY PATHOLOGIC	0.00	2,014.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	909.50
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	37,712.10	800.00
BLOOD	0.00	990.00
BLOOD STORAGE & PRO.	729.00	2,187.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,998.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,950.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	53,412.52	8,116.84
OTHER LAB SERVICES	8,419.30	0.00
RECREATIONAL THERAPY	1,670.00	150.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	20,998.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	200,910.01	33,834.30
MRI SERVICES	40,712.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	28,650.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,114.89	298.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	2.50	0.00

TOTAL ANCILLARY	1,210,718.40	167,949.07
TOTAL ACCOMODATIONS	0.00	1,440.00
TOTAL CHARGES	1,210,718.40	169,389.07

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	20,838.66	ADJUSTMENTS	0.00
COVERED CHARGES	17,581.14	CONTRACTUAL ALLOW	3,555.47
NON-COVERED CHARGES	3,257.52	TOTAL MEDICAID LIAB	14,025.67
		LESS: COB	14,025.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	657.33-
		FEE SCHEDULE-LAB	559.27
		INJECTABLE DRUGS	98.06

TOTAL NUMBER OF CLAIMS 32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	745.15	237.00
MED/SURG SUPPLY	878.58	390.73
LABORATORY-GENERAL	0.00	256.00
RADIOLOGY-DIAGNOSTIC	1,609.30	0.00
CT SCAN	925.65	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	440.00	0.00
IV THERAPY	500.00	50.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	250.00	0.00
GI SERVICES	1,500.00	0.00
EMERGENCY ROOM	4,282.00	238.00
RECOVERY ROOM	1,200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	546.24	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	410.00	50.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	82.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,140.00	904.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,035.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	154.22	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	14.79

TOTAL ANCILLARY	17,581.14	3,257.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,581.14	3,257.52

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	90,584.16	ADJUSTMENTS	444.00
COVERED CHARGES	86,116.61	CONTRACTUAL ALLOW	68,979.61
NON-COVERED CHARGES	4,467.55	TOTAL MEDICAID LIAB	17,137.00
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	16,825.00

TOTAL NUMBER OF CLAIMS 343

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,901.31	0.00
MED/SURG SUPPLY	1,180.76	460.55
LABORATORY-GENERAL	11,058.90	1,108.00
RADIOLOGY-DIAGNOSTIC	3,054.95	146.50
CT SCAN	2,776.95	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	880.00	0.00
IV THERAPY	1,100.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	57,224.00	1,012.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	400.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50.00	0.00
OTHER LAB SERVICES	1,032.70	0.00
RECREATIONAL THERAPY	50.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,610.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	105.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,407.04	25.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,116.61	4,467.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,116.61	4,467.55

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,677.76	ADJUSTMENTS	0.00
COVERED CHARGES	2,153.76	CONTRACTUAL ALLOW	397.98
NON-COVERED CHARGES	524.00	TOTAL MEDICAID LIAB	1,755.78
		LESS: COB	1,752.78
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	237.26	0.00
MED/SURG SUPPLY	26.80	0.00
LABORATORY-GENERAL	644.00	379.00
RADIOLOGY-DIAGNOSTIC	189.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	677.00	95.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	338.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	50.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,153.76	524.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,153.76	524.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	100,827.65	ADJUSTMENTS	0.00
COVERED CHARGES	77,273.55	CONTRACTUAL ALLOW	42,369.45
NON-COVERED CHARGES	23,554.10	TOTAL MEDICAID LIAB	34,904.10
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	34,889.10

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,386.13	0.00
MED/SURG SUPPLY	24,041.63	0.00
LABORATORY-GENERAL	0.00	144.00
RADIOLOGY-DIAGNOSTIC	1,850.90	98.65
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,100.00	0.00
IV THERAPY	378.00	0.00
OPERATING ROOM	9,153.00	7,532.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	693.40	0.00
ANESTHESIA	7,547.00	0.00
GI SERVICES	2,800.00	0.00
EMERGENCY ROOM	325.00	0.00
RECOVERY ROOM	8,756.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	420.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,207.74	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,815.70	584.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	15,175.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	798.20	19.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	77,273.55	23,554.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,273.55	23,554.10

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	343,192.58	ADJUSTMENTS	12,188.85
COVERED CHARGES	334,739.87	CONTRACTUAL ALLOW	115,194.41
NON-COVERED CHARGES	8,452.71	TOTAL MEDICAID LIAB	219,545.46
		LESS: COB	4,576.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	214,969.46

TOTAL NUMBER OF ADMISSIONS 41

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	127	0	59,351.00	2,216.80
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	127	0	59,351.00	2,216.80
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	127	0	59,351.00	2,216.80

INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,267.76	0.00
MED/SURG SUPPLY	21,527.25	166.26
LABORATORY-GENERAL	55,706.03	1,624.00
RADIOLOGY-DIAGNOSTIC	11,667.35	0.00
CT SCAN	15,342.06	0.00
PHYSICAL THERAPY	645.93	0.00
EKG/ECG	9,180.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,554.40	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,860.81	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,568.02	0.00
EMERGENCY ROOM	19,462.42	0.00
RECOVERY ROOM	5,136.00	0.00
LABORATORY PATHOLOGIC	308.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,211.01	0.00
SPEECH PATHOLOGY	842.81	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,013.59	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,560.06
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,279.12	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,544.07	0.00
OTHER LAB SERVICES	4,197.04	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,949.54
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,008.13	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	636.65
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	243.60
INJECTABLE DRUGS	13,066.31	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	55.80

TOTAL ANCILLARY	275,388.87	6,235.91
TOTAL ACCOMODATIONS	59,351.00	2,216.80
TOTAL CHARGES	334,739.87	8,452.71

ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	887,511.39	ADJUSTMENTS	3,952.60
COVERED CHARGES	793,142.58	CONTRACTUAL ALLOW	393,219.37
NON-COVERED CHARGES	94,368.81	TOTAL MEDICAID LIAB	399,923.21
		LESS: COB	293.96
		LESS: COPAYMENT	642.00
		REIMBURSEMENT	398,987.25
		ALL OTHER	374,699.80
		FEE SCHEDULE-LAB	18,437.16
		INJECTABLE DRUGS	5,850.29

TOTAL NUMBER OF CLAIMS 1,154

OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,207.40	3,055.49
MED/SURG SUPPLY	34,765.16	7,604.05
LABORATORY-GENERAL	0.00	6,049.12
RADIOLOGY-DIAGNOSTIC	79,333.98	6,490.61
CT SCAN	62,638.71	13,604.49
PHYSICAL THERAPY	98.80	0.00
EKG/ECG	16,242.60	470.80
IV THERAPY	0.00	374.50
OPERATING ROOM	5,321.01	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,972.88	0.00
ANESTHESIA	267.50	0.00
GI SERVICES	15,982.53	2,500.53
EMERGENCY ROOM	279,737.27	6,983.89
RECOVERY ROOM	9,630.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	21,947.09	74.95
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,509.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	37,361.07	2,730.68
OTHER LAB SERVICES	7,304.13	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,704.34
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	141,697.84	31,686.28
MRI SERVICES	11,079.02	1,900.58

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,861.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	238.60
INJECTABLE DRUGS	10,046.19	4,556.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	793,142.58	93,887.31
TOTAL ACCOMODATIONS	0.00	481.50
TOTAL CHARGES	793,142.58	94,368.81

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,639.29	ADJUSTMENTS	0.00
COVERED CHARGES	5,281.35	CONTRACTUAL ALLOW	1,422.85
NON-COVERED CHARGES	357.94	TOTAL MEDICAID LIAB	3,858.50
		LESS: COB	3,858.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	120.42-
		FEE SCHEDULE-LAB	106.64
		INJECTABLE DRUGS	13.78

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268.51	112.35
MED/SURG SUPPLY	73.69	137.52
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	741.45	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	470.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,949.99	13.91
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	753.28	19.26
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	74.90
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23.63	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,281.35	357.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,281.35	357.94

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	90,790.85	ADJUSTMENTS	50.00
COVERED CHARGES	88,907.28	CONTRACTUAL ALLOW	77,157.28
NON-COVERED CHARGES	1,883.57	TOTAL MEDICAID LIAB	11,750.00
		LESS: COB	0.90
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	11,482.10

TOTAL NUMBER OF CLAIMS 235

OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,945.78	0.00
MED/SURG SUPPLY	848.54	218.63
LABORATORY-GENERAL	10,583.04	479.31
RADIOLOGY-DIAGNOSTIC	6,589.38	320.00
CT SCAN	2,218.74	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	941.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	59,573.01	702.99
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	699.29	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	87.74
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,900.58	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	74.90
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,607.32	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	88,907.28	1,883.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,907.28	1,883.57

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,419.92	ADJUSTMENTS	0.00
COVERED CHARGES	1,419.92	CONTRACTUAL ALLOW	1,147.62
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	272.30
		LESS: COB	269.30
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	60.99	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	997.24	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	347.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.89	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,419.92	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,419.92	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	38,057.05	ADJUSTMENTS	0.00
COVERED CHARGES	37,538.34	CONTRACTUAL ALLOW	21,420.82
NON-COVERED CHARGES	518.71	TOTAL MEDICAID LIAB	16,117.52
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	16,099.52

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP140

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,731.82	243.96
MED/SURG SUPPLY	14,783.14	40.01
LABORATORY-GENERAL	0.00	164.12
RADIOLOGY-DIAGNOSTIC	888.62	0.00
CT SCAN	2,074.18	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	235.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,888.04	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	6,420.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,215.82	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,297.58	70.62
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	37,538.34	518.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,538.34	518.71

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER COUNTY HOSPITAL AUTH.
5995 SPRING STREET
WARM SPRINGS GA 31830-2149

PROVIDER NUMBER 000001284A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP140

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,803,353.65	ADJUSTMENTS	2,926.68
COVERED CHARGES	3,695,520.14	CONTRACTUAL ALLOW	1,690,808.49
NON-COVERED CHARGES	107,833.51	TOTAL MEDICAID LIAB	2,004,711.65
		LESS: COB	16,963.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,987,748.13

TOTAL NUMBER OF ADMISSIONS 558

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,093	3	349,760.00	960.00
NURSERY CARE CHARGES	399	0	127,680.00	1,008.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,492	3	477,440.00	1,968.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	253	0	170,775.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	253	0	170,775.00	0.00
TOTAL ACCOMODATIONS	1,745	3	648,215.00	1,968.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,042,185.18	0.00
MED/SURG SUPPLY	329,270.91	11,073.13
LABORATORY-GENERAL	468,923.50	213.50
RADIOLOGY-DIAGNOSTIC	30,242.00	0.00
CT SCAN	0.00	58,329.00
PHYSICAL THERAPY	14,583.00	0.00
EKG/ECG	7,767.00	0.00
IV THERAPY	297.00	0.00
OPERATING ROOM	252,907.74	0.00
LABOR/DELIVERY ROOM	335,451.00	0.00
RESPIRATORY SERVICES	287,676.00	0.00
ANESTHESIA	41,137.05	0.00
GI SERVICES	10,360.00	0.00
EMERGENCY ROOM	55,410.00	533.00
RECOVERY ROOM	39,277.00	0.00
LABORATORY PATHOLOGIC	9,660.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,708.00	0.00
SPEECH PATHOLOGY	179.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	162.00	0.00
CLINIC SERVICES	0.00	20,460.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,732.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,381.50	5,028.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,241.00	0.00
AUDIOLOGY	0.00	7,300.00
CARDIOLOGY	34,757.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	972.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,216.14	1,070.00
OTHER LAB SERVICES	1,869.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,642.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	297.12	1,858.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,047,305.14	105,865.51
TOTAL ACCOMODATIONS	648,215.00	1,968.00
TOTAL CHARGES	3,695,520.14	107,833.51

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,573,500.92	ADJUSTMENTS	11,726.57
COVERED CHARGES	2,359,165.80	CONTRACTUAL ALLOW	1,346,390.94
NON-COVERED CHARGES	214,335.12	TOTAL MEDICAID LIAB	1,012,774.86
		LESS: COB	1,021.84
		LESS: COPAYMENT	4,806.00
		REIMBURSEMENT	1,006,947.02
		ALL OTHER	939,835.25
		FEE SCHEDULE-LAB	65,934.71
		INJECTABLE DRUGS	1,177.06

TOTAL NUMBER OF CLAIMS 4,600

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215,945.24	7,401.55
MED/SURG SUPPLY	79,074.21	1,674.15
LABORATORY-GENERAL	0.00	4,389.00
RADIOLOGY-DIAGNOSTIC	124,723.50	6,031.50
CT SCAN	146,270.00	6,812.00
PHYSICAL THERAPY	89,521.50	18,810.00
EKG/ECG	17,877.00	400.00
IV THERAPY	35,005.50	378.00
OPERATING ROOM	328,728.12	24,498.00
LABOR/DELIVERY ROOM	12,910.00	0.00
RESPIRATORY SERVICES	23,545.50	1,261.50
ANESTHESIA	41,973.80	1,731.00
GI SERVICES	13,810.00	0.00
EMERGENCY ROOM	381,100.00	19,225.00
RECOVERY ROOM	32,852.00	712.00
LABORATORY PATHOLOGIC	0.00	750.00
RADIOLOGY THERAPEUTIC	325.00	0.00
OCCUPATIONAL THERAPY	40,073.00	8,048.00
SPEECH PATHOLOGY	5,440.00	445.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	594.50	0.00
CLINIC SERVICES	8,700.50	620.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	42,384.50	822.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,883.50	845.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,471.00	540.00
AUDIOLOGY	900.00	0.00
CARDIOLOGY	115,047.00	2,430.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,807.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	79,512.68	1,871.00
OTHER LAB SERVICES	9,474.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	175.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	375,331.00	76,730.00
MRI SERVICES	75,120.00	1,836.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	320.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,270.25	26,073.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,359,165.80	214,335.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,359,165.80	214,335.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,882.44	ADJUSTMENTS	0.00
COVERED CHARGES	11,644.52	CONTRACTUAL ALLOW	3,907.98
NON-COVERED CHARGES	2,237.92	TOTAL MEDICAID LIAB	7,736.54
		LESS: COB	7,712.54
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	627.95-
		FEE SCHEDULE-LAB	618.65
		INJECTABLE DRUGS	9.30

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,282.91	0.00
MED/SURG SUPPLY	583.46	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	710.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	906.00
EKG/ECG	65.00	0.00
IV THERAPY	270.00	0.00
OPERATING ROOM	1,102.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	99.00	49.50
ANESTHESIA	162.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,402.00	160.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	388.00
SPEECH PATHOLOGY	0.00	178.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	324.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	189.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	146.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,288.50	504.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19.65	51.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,644.52	2,237.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,644.52	2,237.92

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	100,900.37	ADJUSTMENTS	176.00
COVERED CHARGES	97,450.81	CONTRACTUAL ALLOW	81,796.81
NON-COVERED CHARGES	3,449.56	TOTAL MEDICAID LIAB	15,654.00
		LESS: COB	0.00
		LESS: COPAYMENT	375.00
		REIMBURSEMENT	15,279.00

TOTAL NUMBER OF CLAIMS 334

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,324.87	0.00
MED/SURG SUPPLY	2,979.99	0.00
LABORATORY-GENERAL	14,174.00	1,946.50
RADIOLOGY-DIAGNOSTIC	3,422.50	0.00
CT SCAN	5,367.00	0.00
PHYSICAL THERAPY	198.00	0.00
EKG/ECG	260.00	0.00
IV THERAPY	108.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	218.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	56,302.00	1,281.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	163.00
RADIOLOGY THERAPEUTIC	71.50	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	259.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	501.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	459.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,206.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	22.06
INJECTABLE DRUGS	598.95	37.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	97,450.81	3,449.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	97,450.81	3,449.56

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	160.00	ADJUSTMENTS	0.00
COVERED CHARGES	160.00	CONTRACTUAL ALLOW	100.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	60.00
		LESS: COB	60.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	160.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	160.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	160.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	464,116.79	ADJUSTMENTS	0.00
COVERED CHARGES	458,055.29	CONTRACTUAL ALLOW	370,183.45
NON-COVERED CHARGES	6,061.50	TOTAL MEDICAID LIAB	87,871.84
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	87,817.84

TOTAL NUMBER OF CLAIMS 22

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,669.70	0.00
MED/SURG SUPPLY	6,339.94	0.00
LABORATORY-GENERAL	0.00	3,875.00
RADIOLOGY-DIAGNOSTIC	205.00	108.00
CT SCAN	19,890.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	65.00	0.00
IV THERAPY	648.00	0.00
OPERATING ROOM	17,799.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	445.50	0.00
ANESTHESIA	1,608.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,092.00	0.00
LABORATORY PATHOLOGIC	0.00	12.50
RADIOLOGY THERAPEUTIC	15,237.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	173.00	173.00
CLINIC SERVICES	3,258.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,129.50	1,893.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	273,494.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	458,055.29	6,061.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	458,055.29	6,061.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,051,516.64	ADJUSTMENTS	13,037.22
COVERED CHARGES	4,022,253.20	CONTRACTUAL ALLOW	1,939,967.54
NON-COVERED CHARGES	29,263.44	TOTAL MEDICAID LIAB	2,082,285.66
		LESS: COB	12,138.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,070,146.69

TOTAL NUMBER OF ADMISSIONS 556

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,162	0	371,840.00	0.00
NURSERY CARE CHARGES	362	0	115,840.00	1,792.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,524	0	487,680.00	1,792.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	280	0	189,000.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	280	0	189,000.00	0.00
TOTAL ACCOMODATIONS	1,804	0	676,680.00	1,792.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,156,873.67	0.00
MED/SURG SUPPLY	336,541.82	8,145.44
LABORATORY-GENERAL	568,323.50	0.00
RADIOLOGY-DIAGNOSTIC	43,926.00	0.00
CT SCAN	76,902.00	5,603.00
PHYSICAL THERAPY	14,650.00	0.00
EKG/ECG	10,247.00	0.00
IV THERAPY	432.00	0.00
OPERATING ROOM	264,545.48	0.00
LABOR/DELIVERY ROOM	241,797.00	0.00
RESPIRATORY SERVICES	348,207.50	0.00
ANESTHESIA	43,897.45	0.00
GI SERVICES	2,590.00	0.00
EMERGENCY ROOM	66,981.75	0.00
RECOVERY ROOM	36,441.00	0.00
LABORATORY PATHOLOGIC	11,280.00	0.00
RADIOLOGY THERAPEUTIC	0.00	468.00
OCCUPATIONAL THERAPY	4,209.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	86.50	0.00
CLINIC SERVICES	0.00	4,044.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,002.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,615.50	1,780.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,674.00	0.00
AUDIOLOGY	0.00	6,850.00
CARDIOLOGY	34,203.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	648.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	34,395.53	581.00
OTHER LAB SERVICES	2,862.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,241.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,345,573.20	27,471.44
TOTAL ACCOMODATIONS	676,680.00	1,792.00
TOTAL CHARGES	4,022,253.20	29,263.44

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,381.80	ADJUSTMENTS	0.00
COVERED CHARGES	8,381.80	CONTRACTUAL ALLOW	2,254.30
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	6,127.50
		LESS: COB	6,127.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5	0	1,600.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	1,600.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	1,600.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	806.45	0.00
MED/SURG SUPPLY	354.35	0.00
LABORATORY-GENERAL	559.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	4,846.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	216.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,781.80	0.00
TOTAL ACCOMODATIONS	1,600.00	0.00
TOTAL CHARGES	8,381.80	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,580,712.05	ADJUSTMENTS	31,920.29
COVERED CHARGES	2,366,616.17	CONTRACTUAL ALLOW	1,409,093.89
NON-COVERED CHARGES	214,095.88	TOTAL MEDICAID LIAB	957,522.28
		LESS: COB	6,064.57
		LESS: COPAYMENT	3,447.00
		REIMBURSEMENT	948,010.71
		ALL OTHER	869,517.70
		FEE SCHEDULE-LAB	78,360.93
		INJECTABLE DRUGS	132.08

TOTAL NUMBER OF CLAIMS 4,704

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209,689.34	5,039.20
MED/SURG SUPPLY	70,848.44	1,064.30
LABORATORY-GENERAL	0.00	7,742.00
RADIOLOGY-DIAGNOSTIC	135,708.00	3,207.50
CT SCAN	165,002.00	0.00
PHYSICAL THERAPY	94,572.00	762.00
EKG/ECG	16,568.00	65.00
IV THERAPY	36,377.00	702.00
OPERATING ROOM	297,206.00	25,627.00
LABOR/DELIVERY ROOM	12,830.00	0.00
RESPIRATORY SERVICES	48,853.00	0.00
ANESTHESIA	35,164.05	1,986.70
GI SERVICES	7,805.00	0.00
EMERGENCY ROOM	419,723.00	379.00
RECOVERY ROOM	25,387.00	1,061.00
LABORATORY PATHOLOGIC	0.00	12.50
RADIOLOGY THERAPEUTIC	4,238.00	0.00
OCCUPATIONAL THERAPY	41,402.00	552.00
SPEECH PATHOLOGY	8,857.50	179.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	2,540.00	0.00
CLINIC SERVICES	1,470.50	1,102.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,994.50	1,132.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,987.00	951.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,230.00	0.00
AUDIOLOGY	1,100.00	0.00
CARDIOLOGY	106,272.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	23,885.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	69,272.92	860.00
OTHER LAB SERVICES	9,720.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	125.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	404,865.50	53,226.50
MRI SERVICES	52,644.00	2,754.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	19.15
INJECTABLE DRUGS	278.92	105,671.03
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,366,616.17	214,095.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,366,616.17	214,095.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
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PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	65,689.60	ADJUSTMENTS	0.00
COVERED CHARGES	56,320.82	CONTRACTUAL ALLOW	16,848.57
NON-COVERED CHARGES	9,368.78	TOTAL MEDICAID LIAB	39,472.25
		LESS: COB	39,436.25
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,685.55-
		FEE SCHEDULE-LAB	1,685.55
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
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TITLE XVIII NO: 110086
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,153.07	0.00
MED/SURG SUPPLY	1,414.35	60.00
LABORATORY-GENERAL	0.00	2,497.00
RADIOLOGY-DIAGNOSTIC	1,892.50	162.00
CT SCAN	5,779.00	0.00
PHYSICAL THERAPY	2,086.00	172.00
EKG/ECG	162.00	0.00
IV THERAPY	594.00	0.00
OPERATING ROOM	2,299.00	0.00
LABOR/DELIVERY ROOM	92.00	0.00
RESPIRATORY SERVICES	355.50	0.00
ANESTHESIA	648.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,495.00	0.00
RECOVERY ROOM	356.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	604.00	0.00
SPEECH PATHOLOGY	470.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	86.50	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,723.00	795.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,215.00	0.00
AUDIOLOGY	50.00	0.00
CARDIOLOGY	5,130.00	189.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	648.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,285.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,782.90	2,520.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	732.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	56,320.82	7,128.78
TOTAL ACCOMODATIONS	0.00	2,240.00
TOTAL CHARGES	56,320.82	9,368.78

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	90,891.89	ADJUSTMENTS	400.00
COVERED CHARGES	89,253.69	CONTRACTUAL ALLOW	72,752.69
NON-COVERED CHARGES	1,638.20	TOTAL MEDICAID LIAB	16,501.00
		LESS: COB	60.73
		LESS: COPAYMENT	252.00
		REIMBURSEMENT	16,188.27

TOTAL NUMBER OF CLAIMS 356

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,621.50	0.00
MED/SURG SUPPLY	2,092.69	0.00
LABORATORY-GENERAL	9,539.50	604.50
RADIOLOGY-DIAGNOSTIC	2,743.00	0.00
CT SCAN	2,903.00	0.00
PHYSICAL THERAPY	2,932.00	0.00
EKG/ECG	260.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	579.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,323.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	34.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	592.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,368.00	386.00
OTHER LAB SERVICES	378.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	918.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.50	613.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	89,253.69	1,638.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	89,253.69	1,638.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,927.20	ADJUSTMENTS	0.00
COVERED CHARGES	1,923.70	CONTRACTUAL ALLOW	838.14
NON-COVERED CHARGES	3.50	TOTAL MEDICAID LIAB	1,085.56
		LESS: COB	1,079.56
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	349.20	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	286.50	0.00
RADIOLOGY-DIAGNOSTIC	219.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,019.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,923.70	3.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,923.70	3.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	156,896.50	ADJUSTMENTS	0.00
COVERED CHARGES	154,661.00	CONTRACTUAL ALLOW	115,298.80
NON-COVERED CHARGES	2,235.50	TOTAL MEDICAID LIAB	39,362.20
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	39,344.20

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
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PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 110086

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,051.55	0.00
MED/SURG SUPPLY	8,563.35	0.00
LABORATORY-GENERAL	0.00	156.00
RADIOLOGY-DIAGNOSTIC	353.00	0.00
CT SCAN	3,315.00	0.00
PHYSICAL THERAPY	4,704.00	0.00
EKG/ECG	130.00	0.00
IV THERAPY	1,566.00	0.00
OPERATING ROOM	6,155.00	1,635.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,996.00	0.00
ANESTHESIA	756.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	356.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,147.50	0.00
OCCUPATIONAL THERAPY	4,527.00	0.00
SPEECH PATHOLOGY	350.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,124.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,519.60	281.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	163.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	154,661.00	2,235.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	154,661.00	2,235.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,926,179.09	ADJUSTMENTS	45,348.76
COVERED CHARGES	3,903,920.29	CONTRACTUAL ALLOW	1,647,274.14
NON-COVERED CHARGES	22,258.80	TOTAL MEDICAID LIAB	2,256,646.15
		LESS: COB	43,297.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,213,348.77

TOTAL NUMBER OF ADMISSIONS 636

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,300	0	416,000.00	0.00
NURSERY CARE CHARGES	421	0	134,720.00	2,128.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,721	0	550,720.00	2,128.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	224	0	151,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	224	0	151,200.00	0.00
TOTAL ACCOMODATIONS	1,945	0	701,920.00	2,128.00

INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,067,228.20	0.00
MED/SURG SUPPLY	333,351.47	8,954.35
LABORATORY-GENERAL	524,595.50	0.00
RADIOLOGY-DIAGNOSTIC	49,853.50	0.00
CT SCAN	50,105.00	0.00
PHYSICAL THERAPY	16,646.00	0.00
EKG/ECG	8,450.00	0.00
IV THERAPY	4,293.00	0.00
OPERATING ROOM	291,371.12	0.00
LABOR/DELIVERY ROOM	295,594.00	0.00
RESPIRATORY SERVICES	258,624.00	0.00
ANESTHESIA	49,915.50	0.00
GI SERVICES	5,180.00	0.00
EMERGENCY ROOM	89,066.00	0.00
RECOVERY ROOM	41,978.00	0.00
LABORATORY PATHOLOGIC	4,985.50	0.00
RADIOLOGY THERAPEUTIC	433.00	390.00
OCCUPATIONAL THERAPY	4,475.00	0.00
SPEECH PATHOLOGY	502.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	86.50	0.00
CLINIC SERVICES	0.00	572.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,714.00	189.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,673.00	356.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,026.00	0.00
AUDIOLOGY	0.00	8,100.00
CARDIOLOGY	38,388.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,451.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,662.00	818.00
OTHER LAB SERVICES	3,618.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,735.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	366.50
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	384.45

TOTAL ANCILLARY	3,202,000.29	20,130.80
TOTAL ACCOMODATIONS	701,920.00	2,128.00
TOTAL CHARGES	3,903,920.29	22,258.80

ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,785,759.70	ADJUSTMENTS	86,831.65
COVERED CHARGES	2,636,377.93	CONTRACTUAL ALLOW	1,699,917.89
NON-COVERED CHARGES	149,381.77	TOTAL MEDICAID LIAB	936,460.04
		LESS: COB	5,259.74
		LESS: COPAYMENT	3,114.00
		REIMBURSEMENT	928,086.30
		ALL OTHER	828,712.24
		FEE SCHEDULE-LAB	97,443.17
		INJECTABLE DRUGS	1,930.89

TOTAL NUMBER OF CLAIMS 5,076

OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	287,150.13	747.00
MED/SURG SUPPLY	88,760.05	1,589.30
LABORATORY-GENERAL	0.00	9,824.00
RADIOLOGY-DIAGNOSTIC	137,276.50	4,121.00
CT SCAN	136,653.00	4,543.00
PHYSICAL THERAPY	91,611.00	2,063.00
EKG/ECG	15,796.00	65.00
IV THERAPY	64,876.50	471.00
OPERATING ROOM	343,994.61	8,159.50
LABOR/DELIVERY ROOM	9,328.00	0.00
RESPIRATORY SERVICES	38,371.50	0.00
ANESTHESIA	52,861.50	372.50
GI SERVICES	18,425.00	865.00
EMERGENCY ROOM	503,849.50	1,096.00
RECOVERY ROOM	27,539.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,498.00	0.00
OCCUPATIONAL THERAPY	32,983.00	2,272.00
SPEECH PATHOLOGY	22,367.50	289.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	4,454.00	0.00
CLINIC SERVICES	162.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	39,593.00	1,076.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,264.00	1,189.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,256.00	405.00
AUDIOLOGY	800.00	676.00
CARDIOLOGY	89,910.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,574.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	78,626.54	1,144.00
OTHER LAB SERVICES	7,641.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	150.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	448,408.00	52,898.50
MRI SERVICES	49,193.00	918.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	82.80
INJECTABLE DRUGS	5,004.60	53,809.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	705.40

TOTAL ANCILLARY	2,636,377.93	149,381.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,636,377.93	149,381.77

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	86,349.46	ADJUSTMENTS	0.00
COVERED CHARGES	78,488.61	CONTRACTUAL ALLOW	33,960.08
NON-COVERED CHARGES	7,860.85	TOTAL MEDICAID LIAB	44,528.53
		LESS: COB	44,525.53
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,976.94-
		FEE SCHEDULE-LAB	1,914.97
		INJECTABLE DRUGS	61.97

TOTAL NUMBER OF CLAIMS 157

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,584.60	34.35
MED/SURG SUPPLY	1,855.05	5.50
LABORATORY-GENERAL	0.00	277.50
RADIOLOGY-DIAGNOSTIC	2,006.00	0.00
CT SCAN	675.00	0.00
PHYSICAL THERAPY	6,304.00	216.00
EKG/ECG	195.00	0.00
IV THERAPY	1,220.00	0.00
OPERATING ROOM	2,186.50	5,335.00
LABOR/DELIVERY ROOM	1,223.00	0.00
RESPIRATORY SERVICES	643.50	0.00
ANESTHESIA	1,035.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,030.00	0.00
RECOVERY ROOM	712.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,184.00	288.00
SPEECH PATHOLOGY	7,607.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,461.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	133.50	435.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,989.00	189.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,041.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,242.00	920.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	160.56	120.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	40.00

TOTAL ANCILLARY	78,488.61	7,860.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,488.61	7,860.85

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	91,518.83	ADJUSTMENTS	447.00
COVERED CHARGES	90,765.38	CONTRACTUAL ALLOW	72,066.38
NON-COVERED CHARGES	753.45	TOTAL MEDICAID LIAB	18,699.00
		LESS: COB	60.30
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	18,275.70

TOTAL NUMBER OF CLAIMS 381

OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,770.03	0.00
MED/SURG SUPPLY	2,121.90	0.00
LABORATORY-GENERAL	6,876.50	203.50
RADIOLOGY-DIAGNOSTIC	3,900.00	203.50
CT SCAN	1,350.00	0.00
PHYSICAL THERAPY	583.00	100.00
EKG/ECG	65.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	609.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	63,971.00	92.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,996.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	522.95	154.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	90,765.38	753.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,765.38	753.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,728.61	ADJUSTMENTS	0.00
COVERED CHARGES	2,626.11	CONTRACTUAL ALLOW	1,212.61
NON-COVERED CHARGES	102.50	TOTAL MEDICAID LIAB	1,413.50
		LESS: COB	1,407.50
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173.46	0.00
MED/SURG SUPPLY	5.50	0.00
LABORATORY-GENERAL	450.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,634.00	92.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	189.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	149.15	10.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,626.11	102.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,626.11	102.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	153,044.28	ADJUSTMENTS	3,430.60
COVERED CHARGES	152,117.13	CONTRACTUAL ALLOW	124,648.33
NON-COVERED CHARGES	927.15	TOTAL MEDICAID LIAB	27,468.80
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	27,423.80

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
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PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,663.93	0.00
MED/SURG SUPPLY	3,587.70	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97.00	0.00
CT SCAN	6,630.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	195.00	0.00
IV THERAPY	7,619.00	0.00
OPERATING ROOM	23,704.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.00	0.00
ANESTHESIA	2,079.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,609.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,354.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	519.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,956.00	800.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	126.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	152,117.13	927.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	152,117.13	927.15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL OF WASHINGTON CO
610 SPARTA ROAD
BOX 636
SANDERSVILLE GA 31082-1860

PROVIDER NUMBER 000001218A
NUMBER OF BEDS 56
TITLE XVIII NO: 110086

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,025,067.48	ADJUSTMENTS	777,550.05
COVERED CHARGES	7,950,400.68	CONTRACTUAL ALLOW	4,495,376.30
NON-COVERED CHARGES	74,666.80	TOTAL MEDICAID LIAB	3,455,024.38
		LESS: COB	8,640.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,446,383.44

TOTAL NUMBER OF ADMISSIONS 1,064

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,273	0	706,903.00	70,013.00
NURSERY CARE CHARGES	722	0	151,182.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,995	0	858,085.00	70,013.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	307	0	246,214.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	307	0	246,214.00	0.00
TOTAL ACCOMODATIONS	3,302	0	1,104,299.00	70,013.00

INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,550,806.50	0.00
MED/SURG SUPPLY	1,638,841.36	0.00
LABORATORY-GENERAL	835,382.19	0.00
RADIOLOGY-DIAGNOSTIC	98,095.11	0.00
CT SCAN	176,966.80	0.00
PHYSICAL THERAPY	19,902.69	0.00
EKG/ECG	22,760.10	0.00
IV THERAPY	18,315.10	0.00
OPERATING ROOM	325,288.30	0.00
LABOR/DELIVERY ROOM	265,764.95	0.00
RESPIRATORY SERVICES	100,116.71	0.00
ANESTHESIA	17,449.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	144,951.95	0.00
RECOVERY ROOM	57,582.20	0.00
LABORATORY PATHOLOGIC	29,291.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	193.90	0.00
RENAL DIALYSIS	1,840.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	32,286.80	0.00
OTHER IMAGING SERVICES	34,861.55	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	73,067.08	3,171.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,324.50	0.00
AUDIOLOGY	18,929.65	0.00
CARDIOLOGY	45,580.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55,125.55	0.00
OTHER LAB SERVICES	9,338.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	35,152.05	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,482.30
INJECTABLE DRUGS	215,885.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,846,101.68	4,653.80
TOTAL ACCOMODATIONS	1,104,299.00	70,013.00
TOTAL CHARGES	7,950,400.68	74,666.80

ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	957.15	ADJUSTMENTS	0.00
COVERED CHARGES	957.15	CONTRACTUAL ALLOW	92.37
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	864.78
		LESS: COB	864.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	0	0	0.00	0.00
NURSERY CARE CHARGES	2	0	452.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	452.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	452.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100.35	0.00
MED/SURG SUPPLY	215.30	0.00
LABORATORY-GENERAL	128.05	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	61.45	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	505.15	0.00
TOTAL ACCOMODATIONS	452.00	0.00
TOTAL CHARGES	957.15	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,982,309.12	ADJUSTMENTS	49,795.75
COVERED CHARGES	4,793,442.60	CONTRACTUAL ALLOW	2,830,624.68
NON-COVERED CHARGES	188,866.52	TOTAL MEDICAID LIAB	1,962,817.92
		LESS: COB	741.56
		LESS: COPAYMENT	4,884.00
		REIMBURSEMENT	1,957,192.36
		ALL OTHER	1,767,935.88
		FEE SCHEDULE-LAB	129,024.05
		INJECTABLE DRUGS	60,232.43

TOTAL NUMBER OF CLAIMS 7,162

OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	579,337.49	812.10
MED/SURG SUPPLY	689,431.18	349.52
LABORATORY-GENERAL	1,372.64	6,434.71
RADIOLOGY-DIAGNOSTIC	284,112.70	14,409.00
CT SCAN	403,586.45	1,259.70
PHYSICAL THERAPY	61,364.91	3,936.65
EKG/ECG	29,061.45	282.15
IV THERAPY	32,859.40	152.10
OPERATING ROOM	193,768.85	20,464.60
LABOR/DELIVERY ROOM	113,847.00	0.00
RESPIRATORY SERVICES	21,283.38	529.55
ANESTHESIA	14,251.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	571,819.47	6,067.87
RECOVERY ROOM	55,227.80	199.20
LABORATORY PATHOLOGIC	0.00	25.80
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	16,372.35	0.00
OTHER IMAGING SERVICES	129,718.35	673.21
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,341.60	3,323.11
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,190.65	3,418.05
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,038.20	496.90
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	174,629.10	912.40
OTHER LAB SERVICES	17,382.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	803,545.50	97,016.88
MRI SERVICES	386,002.55	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	374.85	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	129,522.53	27,290.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	10.85
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,793,442.60	188,064.52
TOTAL ACCOMODATIONS	0.00	802.00
TOTAL CHARGES	4,793,442.60	188,866.52

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	15,199.09	ADJUSTMENTS	0.00
COVERED CHARGES	14,281.44	CONTRACTUAL ALLOW	8,983.20
NON-COVERED CHARGES	917.65	TOTAL MEDICAID LIAB	5,298.24
		LESS: COB	5,292.24
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	283.61-
		FEE SCHEDULE-LAB	255.86
		INJECTABLE DRUGS	27.75

TOTAL NUMBER OF CLAIMS 19

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,112.30	0.00
MED/SURG SUPPLY	3,570.83	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	747.00	0.00
CT SCAN	1,137.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	94.05	0.00
IV THERAPY	152.10	0.00
OPERATING ROOM	830.25	0.00
LABOR/DELIVERY ROOM	676.60	0.00
RESPIRATORY SERVICES	35.30	0.00
ANESTHESIA	66.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,324.26	176.40
RECOVERY ROOM	199.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	646.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	429.10	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,185.60	701.65
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74.45	39.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,281.44	917.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,281.44	917.65

OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	257,368.66	ADJUSTMENTS	982.00
COVERED CHARGES	251,406.49	CONTRACTUAL ALLOW	201,406.49
NON-COVERED CHARGES	5,962.17	TOTAL MEDICAID LIAB	50,000.00
		LESS: COB	112.67
		LESS: COPAYMENT	840.00
		REIMBURSEMENT	49,047.33

TOTAL NUMBER OF CLAIMS 1,000

OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,643.40	0.00
MED/SURG SUPPLY	12,242.37	0.00
LABORATORY-GENERAL	35,566.15	1,924.87
RADIOLOGY-DIAGNOSTIC	16,862.60	0.00
CT SCAN	8,715.73	0.00
PHYSICAL THERAPY	0.00	142.60
EKG/ECG	1,598.85	0.00
IV THERAPY	76.05	0.00
OPERATING ROOM	716.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,092.35	0.00
ANESTHESIA	51.10	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,465.38	822.90
RECOVERY ROOM	199.20	0.00
LABORATORY PATHOLOGIC	73.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	681.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,388.60	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,033.26	3,071.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	251,406.49	5,962.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	251,406.49	5,962.17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,052.32	ADJUSTMENTS	0.00
COVERED CHARGES	2,649.07	CONTRACTUAL ALLOW	2,204.28
NON-COVERED CHARGES	403.25	TOTAL MEDICAID LIAB	444.79
		LESS: COB	438.79
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	496.05	0.00
MED/SURG SUPPLY	214.55	0.00
LABORATORY-GENERAL	473.55	0.00
RADIOLOGY-DIAGNOSTIC	339.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,046.22	380.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78.80	23.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,649.07	403.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,649.07	403.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	626,655.48	ADJUSTMENTS	8,153.42
COVERED CHARGES	596,810.66	CONTRACTUAL ALLOW	392,930.10
NON-COVERED CHARGES	29,844.82	TOTAL MEDICAID LIAB	203,880.56
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	203,757.56

TOTAL NUMBER OF CLAIMS 50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,771.27	0.00
MED/SURG SUPPLY	233,471.73	0.00
LABORATORY-GENERAL	1,912.80	1,768.69
RADIOLOGY-DIAGNOSTIC	4,156.40	1,475.00
CT SCAN	9,131.75	1,138.90
PHYSICAL THERAPY	1,398.63	161.15
EKG/ECG	1,881.00	0.00
IV THERAPY	300.55	0.00
OPERATING ROOM	99,642.70	14,291.90
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,025.43	0.00
ANESTHESIA	4,436.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,293.45	176.40
RECOVERY ROOM	11,698.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	80,717.00	0.00
OTHER IMAGING SERVICES	490.15	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,235.80	6,268.88
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	939.45	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,182.05	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,219.80	304.20
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,887.58	4,099.05
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,018.02	160.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	596,810.66	29,844.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	596,810.66	29,844.82

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,272,005.41	ADJUSTMENTS	338,308.87
COVERED CHARGES	8,204,349.36	CONTRACTUAL ALLOW	4,526,559.90
NON-COVERED CHARGES	67,656.05	TOTAL MEDICAID LIAB	3,677,789.46
		LESS: COB	12,294.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,665,495.28

TOTAL NUMBER OF ADMISSIONS 1,087

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,284	0	784,867.00	31,924.00
NURSERY CARE CHARGES	743	0	163,880.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,027	0	948,747.00	31,924.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	352	0	296,678.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	352	0	296,678.00	0.00
TOTAL ACCOMODATIONS	3,379	0	1,245,425.00	31,924.00

INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,434,133.07	0.00
MED/SURG SUPPLY	1,789,969.33	13,944.05
LABORATORY-GENERAL	931,313.33	0.00
RADIOLOGY-DIAGNOSTIC	99,312.40	0.00
CT SCAN	175,472.15	0.00
PHYSICAL THERAPY	20,200.35	0.00
EKG/ECG	20,540.00	0.00
IV THERAPY	14,820.85	11,442.15
OPERATING ROOM	327,588.05	0.00
LABOR/DELIVERY ROOM	294,413.25	0.00
RESPIRATORY SERVICES	118,496.06	0.00
ANESTHESIA	16,927.18	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,277.40	0.00
RECOVERY ROOM	61,184.05	0.00
LABORATORY PATHOLOGIC	30,935.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	670.50	0.00
RENAL DIALYSIS	3,478.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	33,901.20	0.00
OTHER IMAGING SERVICES	36,710.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	89,413.42	1,306.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,344.30	0.00
AUDIOLOGY	21,156.00	0.00
CARDIOLOGY	41,659.10	0.00
AMBULATORY SURGERY	709.40	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	63,445.12	145.55
OTHER LAB SERVICES	9,209.17	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	47,830.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	8,893.80
INJECTABLE DRUGS	145,813.73	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,958,924.36	35,732.05
TOTAL ACCOMODATIONS	1,245,425.00	31,924.00
TOTAL CHARGES	8,204,349.36	67,656.05

ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,354,652.91	ADJUSTMENTS	14,355.19
COVERED CHARGES	5,094,285.56	CONTRACTUAL ALLOW	3,553,195.10
NON-COVERED CHARGES	260,367.35	TOTAL MEDICAID LIAB	1,541,090.46
		LESS: COB	632.10
		LESS: COPAYMENT	4,479.00
		REIMBURSEMENT	1,535,979.36
		ALL OTHER	1,359,626.91
		FEE SCHEDULE-LAB	136,812.76
		INJECTABLE DRUGS	39,539.69

TOTAL NUMBER OF CLAIMS 7,316

OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	597,171.19	0.00
MED/SURG SUPPLY	828,022.16	109.00
LABORATORY-GENERAL	837.00	7,364.63
RADIOLOGY-DIAGNOSTIC	293,658.65	15,648.35
CT SCAN	327,204.60	31,132.45
PHYSICAL THERAPY	47,604.15	273.65
EKG/ECG	30,415.00	0.00
IV THERAPY	67,303.75	19,781.00
OPERATING ROOM	287,636.73	4,639.65
LABOR/DELIVERY ROOM	137,785.25	412.90
RESPIRATORY SERVICES	25,216.80	207.15
ANESTHESIA	18,653.66	61.30
GI SERVICES	0.00	0.00
EMERGENCY ROOM	521,327.90	47,206.75
RECOVERY ROOM	62,907.36	0.00
LABORATORY PATHOLOGIC	0.00	20.25
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	150.00	0.00
LITHOTRIPSY	130,026.90	0.00
OTHER IMAGING SERVICES	174,118.56	1,486.35
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	7,417.54
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	58,896.35	986.45
AUDIOLOGY	0.00	0.00
CARDIOLOGY	29,745.65	0.00
AMBULATORY SURGERY	7,395.90	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	163,037.42	16,708.79
OTHER LAB SERVICES	13,194.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	831,739.87	82,645.51
MRI SERVICES	320,000.50	7,247.35

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	120,236.06	17,018.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,094,285.56	260,367.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,094,285.56	260,367.35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,626.45	ADJUSTMENTS	0.00
COVERED CHARGES	8,286.55	CONTRACTUAL ALLOW	4,970.66
NON-COVERED CHARGES	339.90	TOTAL MEDICAID LIAB	3,315.89
		LESS: COB	3,312.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	322.10-
		FEE SCHEDULE-LAB	286.50
		INJECTABLE DRUGS	35.60

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	734.10	0.00
MED/SURG SUPPLY	2,052.40	0.00
LABORATORY-GENERAL	0.00	95.10
RADIOLOGY-DIAGNOSTIC	199.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	689.75	0.00
LABOR/DELIVERY ROOM	455.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	46.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	793.20	0.00
RECOVERY ROOM	265.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	928.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	330.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,682.60	244.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	108.15	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,286.55	339.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,286.55	339.90

OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	277,590.17	ADJUSTMENTS	1,673.00
COVERED CHARGES	273,202.82	CONTRACTUAL ALLOW	217,852.24
NON-COVERED CHARGES	4,387.35	TOTAL MEDICAID LIAB	55,350.58
		LESS: COB	61.26
		LESS: COPAYMENT	1,359.00
		REIMBURSEMENT	53,930.32

TOTAL NUMBER OF CLAIMS 1,107

OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,069.44	0.00
MED/SURG SUPPLY	14,460.48	0.00
LABORATORY-GENERAL	47,061.51	2,347.20
RADIOLOGY-DIAGNOSTIC	17,195.60	0.00
CT SCAN	8,996.70	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,580.00	0.00
IV THERAPY	3,819.95	85.55
OPERATING ROOM	1,024.05	0.00
LABOR/DELIVERY ROOM	512.95	0.00
RESPIRATORY SERVICES	1,058.55	0.00
ANESTHESIA	76.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	129,820.95	1,954.60
RECOVERY ROOM	398.40	0.00
LABORATORY PATHOLOGIC	227.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	514.65	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	893.21	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	147.30	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,344.88	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	273,202.82	4,387.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	273,202.82	4,387.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,915.93	ADJUSTMENTS	0.00
COVERED CHARGES	11,746.73	CONTRACTUAL ALLOW	11,689.98
NON-COVERED CHARGES	4,169.20	TOTAL MEDICAID LIAB	56.75
		LESS: COB	56.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,685.30	0.00
MED/SURG SUPPLY	842.60	0.00
LABORATORY-GENERAL	1,955.90	207.35
RADIOLOGY-DIAGNOSTIC	1,255.10	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37.05	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,417.05	3,961.85
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	553.73	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,746.73	4,169.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,746.73	4,169.20

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	348,930.58	ADJUSTMENTS	0.00
COVERED CHARGES	327,496.06	CONTRACTUAL ALLOW	239,047.79
NON-COVERED CHARGES	21,434.52	TOTAL MEDICAID LIAB	88,448.27
		LESS: COB	0.00
		LESS: COPAYMENT	135.00
		REIMBURSEMENT	88,313.27

TOTAL NUMBER OF CLAIMS 25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP35

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,123.69	0.00
MED/SURG SUPPLY	129,263.65	0.00
LABORATORY-GENERAL	0.00	90.10
RADIOLOGY-DIAGNOSTIC	1,690.60	277.85
CT SCAN	0.00	0.00
PHYSICAL THERAPY	384.40	0.00
EKG/ECG	493.75	0.00
IV THERAPY	4,526.70	611.20
OPERATING ROOM	52,615.05	1,831.45
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	495.45	0.00
ANESTHESIA	2,481.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	494.05	0.00
RECOVERY ROOM	5,411.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	63,296.45	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,079.37
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,083.40	1,315.40
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,738.45	1,539.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	538.23
INJECTABLE DRUGS	6,397.82	13,151.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	327,496.06	21,434.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	327,496.06	21,434.52

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEM HOSP
865 SOUTH FIRST ST
JESUP GA 31545-0210

PROVIDER NUMBER 000002054A
NUMBER OF BEDS 123
TITLE XVIII NO: HOSP35

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	71,850,526.43	ADJUSTMENTS	3,651,358.73
COVERED CHARGES	68,051,151.13	CONTRACTUAL ALLOW	41,811,481.21
NON-COVERED CHARGES	3,799,375.30	TOTAL MEDICAID LIAB	26,239,669.92
		LESS: COB	190,976.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,048,693.15

TOTAL NUMBER OF ADMISSIONS 7,224

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	14,001	0	7,834,091.00	1,712,850.00
NURSERY CARE CHARGES	7,141	0	2,388,865.00	1,774,380.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	82	0.00	0.00
TOTAL ROUTINE	21,142	82	10,222,956.00	3,487,230.00
SPECIAL CARE SERVICES				
C C U	2,251	0	1,907,480.00	0.00
I C U	2,051	0	2,207,870.00	0.00
N I C U	1,979	0	3,463,955.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	1	0	860.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	189	0.00	156,870.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,282	189	7,580,165.00	156,870.00
TOTAL ACCOMODATIONS	27,424	271	17,803,121.00	3,644,100.00

INPATIENT PAID CLAIMS

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,473,676.99	0.00
MED/SURG SUPPLY	4,569,580.82	47,521.30
LABORATORY-GENERAL	8,339,284.50	0.00
RADIOLOGY-DIAGNOSTIC	1,058,600.00	0.00
CT SCAN	1,577,688.00	0.00
PHYSICAL THERAPY	181,800.00	0.00
EKG/ECG	175,815.00	0.00
IV THERAPY	66,132.00	0.00
OPERATING ROOM	3,585,480.00	0.00
LABOR/DELIVERY ROOM	8,989,120.45	0.00
RESPIRATORY SERVICES	4,325,446.00	0.00
ANESTHESIA	606,439.00	0.00
GI SERVICES	35,616.00	0.00
EMERGENCY ROOM	949,401.00	0.00
RECOVERY ROOM	827,841.00	0.00
LABORATORY PATHOLOGIC	268,117.00	0.00
RADIOLOGY THERAPEUTIC	20,920.00	0.00
OCCUPATIONAL THERAPY	110,828.00	0.00
SPEECH PATHOLOGY	33,240.00	0.00
RENAL DIALYSIS	925,575.00	2,268.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,431.00
PSYCHIATRIC SERVICES	33,520.00	3,016.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	676,062.00	11,853.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	420,266.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	312,833.00	0.00
AUDIOLOGY	515,943.00	0.00
CARDIOLOGY	998,800.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	46,220.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	108,790.07	48,805.00
OTHER LAB SERVICES	343,121.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	150,349.00	4,799.00
OTHER THERAPEUTIC SERVI	0.00	20,541.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	499,771.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	180.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,754.30	0.00
HOME HEALTH SERVICES	0.00	2,503.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	6.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	12,352.00

TOTAL ANCILLARY	50,248,030.13	155,275.30
TOTAL ACCOMODATIONS	17,803,121.00	3,644,100.00
TOTAL CHARGES	68,051,151.13	3,799,375.30

ZERO PAID INPATIENT PAID CLAIMS

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	969,016.40	ADJUSTMENTS	0.00
COVERED CHARGES	950,266.40	CONTRACTUAL ALLOW	87,533.29
NON-COVERED CHARGES	18,750.00	TOTAL MEDICAID LIAB	862,733.11
		LESS: COB	862,733.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 118

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	254	0	142,240.00	1,820.00
NURSERY CARE CHARGES	39	0	14,520.00	15,345.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	293	0	156,760.00	17,165.00
SPECIAL CARE SERVICES				
C C U	4	0	3,060.00	0.00
I C U	28	0	24,090.00	0.00
N I C U	17	0	30,095.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	49	0	57,245.00	0.00
TOTAL ACCOMODATIONS	342	0	214,005.00	17,165.00

ZERO PAID INPATIENT PAID CLAIMS

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,770.40	0.00
MED/SURG SUPPLY	62,117.00	0.00
LABORATORY-GENERAL	72,490.00	0.00
RADIOLOGY-DIAGNOSTIC	7,078.00	0.00
CT SCAN	14,593.00	0.00
PHYSICAL THERAPY	492.00	0.00
EKG/ECG	429.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	73,407.00	0.00
LABOR/DELIVERY ROOM	293,654.00	0.00
RESPIRATORY SERVICES	23,328.00	0.00
ANESTHESIA	6,606.00	0.00
GI SERVICES	1,113.00	0.00
EMERGENCY ROOM	6,529.00	0.00
RECOVERY ROOM	18,607.00	0.00
LABORATORY PATHOLOGIC	5,355.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	136.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,893.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	770.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,561.00	0.00
CARDIOLOGY	3,285.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,124.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	1,259.00
OTHER LAB SERVICES	5,621.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,655.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	648.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	326.00

TOTAL ANCILLARY	736,261.40	1,585.00
TOTAL ACCOMODATIONS	214,005.00	17,165.00
TOTAL CHARGES	950,266.40	18,750.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	24,463,487.46	ADJUSTMENTS	905,380.58
COVERED CHARGES	23,688,555.73	CONTRACTUAL ALLOW	16,945,146.04
NON-COVERED CHARGES	774,931.73	TOTAL MEDICAID LIAB	6,743,409.69
		LESS: COB	7,194.68
		LESS: COPAYMENT	11,541.00
		REIMBURSEMENT	6,724,674.01
		ALL OTHER	6,342,569.59
		FEE SCHEDULE-LAB	380,545.05
		INJECTABLE DRUGS	1,559.37

TOTAL NUMBER OF CLAIMS 24,338

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,504,111.28	31,825.05
MED/SURG SUPPLY	797,492.82	11,952.00
LABORATORY-GENERAL	41,306.00	38,825.00
RADIOLOGY-DIAGNOSTIC	1,621,466.00	17,386.00
CT SCAN	2,338,384.00	7,871.00
PHYSICAL THERAPY	187,739.00	1,750.00
EKG/ECG	132,158.00	143.00
IV THERAPY	184,084.00	1,570.00
OPERATING ROOM	1,483,693.00	38,937.00
LABOR/DELIVERY ROOM	1,218,553.00	1,712.00
RESPIRATORY SERVICES	281,862.00	7,537.00
ANESTHESIA	577,490.00	11,194.00
GI SERVICES	5,280.00	0.00
EMERGENCY ROOM	4,669,959.00	2,800.00
RECOVERY ROOM	533,028.00	0.00
LABORATORY PATHOLOGIC	336.00	168.00
RADIOLOGY THERAPEUTIC	124,493.00	1,068.00
OCCUPATIONAL THERAPY	65,759.00	739.00
SPEECH PATHOLOGY	16,972.00	0.00
RENAL DIALYSIS	0.00	17,573.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,973.00	126.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	988,917.00	16,138.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	45,584.00	13,866.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	242,694.00	1,778.00
AUDIOLOGY	197.00	0.00
CARDIOLOGY	313,499.00	13,838.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,542.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	780,388.83	102,443.98
OTHER LAB SERVICES	102,098.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30,932.00	240.00
OTHER THERAPEUTIC SERVI	0.00	36,879.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,538,081.10	384,136.70
MRI SERVICES	771,029.00	9,032.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	725.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,729.70	1,172.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	522.00

TOTAL ANCILLARY	23,688,555.73	773,221.73
TOTAL ACCOMODATIONS	0.00	1,710.00
TOTAL CHARGES	23,688,555.73	774,931.73

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	394,622.15	ADJUSTMENTS	0.00
COVERED CHARGES	384,077.45	CONTRACTUAL ALLOW	54,672.88
NON-COVERED CHARGES	10,544.70	TOTAL MEDICAID LIAB	329,404.57
		LESS: COB	329,293.57
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	0.00
		ALL OTHER	5,419.04-
		FEE SCHEDULE-LAB	5,419.04
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 267

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,502.75	1,677.70
MED/SURG SUPPLY	15,967.94	1,717.00
LABORATORY-GENERAL	189.00	408.00
RADIOLOGY-DIAGNOSTIC	15,885.00	783.00
CT SCAN	30,945.00	0.00
PHYSICAL THERAPY	4,671.00	0.00
EKG/ECG	1,022.00	0.00
IV THERAPY	1,705.00	468.00
OPERATING ROOM	44,953.00	0.00
LABOR/DELIVERY ROOM	39,025.00	0.00
RESPIRATORY SERVICES	726.00	0.00
ANESTHESIA	20,260.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	45,275.00	0.00
RECOVERY ROOM	18,018.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,431.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	109.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,549.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,293.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,651.76	0.00
OTHER LAB SERVICES	499.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	608.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,507.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,554.00	3,613.00
MRI SERVICES	2,238.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	304.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	67.00

TOTAL ANCILLARY	384,077.45	10,544.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	384,077.45	10,544.70

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,233,486.46	ADJUSTMENTS	8,235.41
COVERED CHARGES	1,208,946.28	CONTRACTUAL ALLOW	1,062,002.87
NON-COVERED CHARGES	24,540.18	TOTAL MEDICAID LIAB	146,943.41
		LESS: COB	206.46
		LESS: COPAYMENT	1,320.00
		REIMBURSEMENT	145,416.95

TOTAL NUMBER OF CLAIMS 2,936

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,401.50	0.00
MED/SURG SUPPLY	9,969.00	815.00
LABORATORY-GENERAL	229,319.50	19,163.50
RADIOLOGY-DIAGNOSTIC	81,866.00	677.00
CT SCAN	65,411.00	0.00
PHYSICAL THERAPY	136.00	0.00
EKG/ECG	8,050.00	0.00
IV THERAPY	234.00	0.00
OPERATING ROOM	2,708.00	0.00
LABOR/DELIVERY ROOM	11,546.00	0.00
RESPIRATORY SERVICES	15,427.00	0.00
ANESTHESIA	733.00	0.00
GI SERVICES	371.00	0.00
EMERGENCY ROOM	668,364.00	0.00
RECOVERY ROOM	1,054.00	0.00
LABORATORY PATHOLOGIC	168.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	39,438.00	519.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	309.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,817.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	495.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,030.08	3,229.68
OTHER LAB SERVICES	10,948.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	74.00	0.00
OTHER THERAPEUTIC SERVI	0.00	136.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,034.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,208,946.28	24,540.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,208,946.28	24,540.18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,915.50	ADJUSTMENTS	0.00
COVERED CHARGES	12,762.50	CONTRACTUAL ALLOW	5,579.86
NON-COVERED CHARGES	153.00	TOTAL MEDICAID LIAB	7,182.64
		LESS: COB	7,173.64
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226.50	0.00
MED/SURG SUPPLY	68.00	6.00
LABORATORY-GENERAL	3,222.00	48.00
RADIOLOGY-DIAGNOSTIC	1,030.00	0.00
CT SCAN	1,283.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	328.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,872.00	99.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	733.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,762.50	153.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,762.50	153.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD

AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,666,267.28	ADJUSTMENTS	84,949.40
COVERED CHARGES	1,632,304.28	CONTRACTUAL ALLOW	1,243,135.25
NON-COVERED CHARGES	33,963.00	TOTAL MEDICAID LIAB	389,169.03
		LESS: COB	2,973.49
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	385,967.54

TOTAL NUMBER OF CLAIMS 96

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0027GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	887,239.40	0.00
MED/SURG SUPPLY	168,720.90	12,888.00
LABORATORY-GENERAL	1,290.00	1,228.00
RADIOLOGY-DIAGNOSTIC	86,912.00	1,037.00
CT SCAN	16,585.00	0.00
PHYSICAL THERAPY	900.00	0.00
EKG/ECG	1,287.00	0.00
IV THERAPY	40,284.00	702.00
OPERATING ROOM	154,738.00	0.00
LABOR/DELIVERY ROOM	12,926.00	0.00
RESPIRATORY SERVICES	1,407.00	0.00
ANESTHESIA	49,123.00	230.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,490.00	0.00
RECOVERY ROOM	24,814.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	53,173.00	1,302.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,793.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,158.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,273.00	3,842.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,615.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,856.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	495.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,105.98	0.00
OTHER LAB SERVICES	1,536.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	6,558.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,922.00	6,093.00
MRI SERVICES	2,661.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	83.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,632,304.28	33,963.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,632,304.28	33,963.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB HOSPITAL &MEDICAL CENTER
3950 AUSTELL RD
AUSTELL GA 30106-1121

PROVIDER NUMBER 000000426A
NUMBER OF BEDS 303
TITLE XVIII NO: HPH0027GA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,203,584.82	ADJUSTMENTS	264,422.11
COVERED CHARGES	12,940,989.96	CONTRACTUAL ALLOW	5,047,638.07
NON-COVERED CHARGES	262,594.86	TOTAL MEDICAID LIAB	7,893,351.89
		LESS: COB	46,238.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,847,113.78

TOTAL NUMBER OF ADMISSIONS 2,358

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,467	0	1,776,775.00	136,580.00
NURSERY CARE CHARGES	2,098	2	558,475.00	25,510.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	0.00
TOTAL ROUTINE	7,565	8	2,335,250.00	162,090.00
SPECIAL CARE SERVICES				
C C U	1,448	0	1,017,520.00	0.00
I C U	0	0	0.00	0.00
N I C U	45	0	26,100.00	0.00
PED I C U	85	0	51,175.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,578	0	1,094,795.00	0.00
TOTAL ACCOMODATIONS	9,143	8	3,430,045.00	162,090.00

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,381,697.95	140.86
MED/SURG SUPPLY	1,378,656.07	22,747.00
LABORATORY-GENERAL	1,262,087.00	57,290.00
RADIOLOGY-DIAGNOSTIC	175,720.00	0.00
CT SCAN	279,412.00	14,040.00
PHYSICAL THERAPY	70,384.00	0.00
EKG/ECG	38,581.00	0.00
IV THERAPY	25,911.00	0.00
OPERATING ROOM	1,326,199.94	0.00
LABOR/DELIVERY ROOM	710,511.00	0.00
RESPIRATORY SERVICES	494,566.80	0.00
ANESTHESIA	189,452.00	0.00
GI SERVICES	49,752.00	0.00
EMERGENCY ROOM	249,457.00	0.00
RECOVERY ROOM	90,967.00	0.00
LABORATORY PATHOLOGIC	139,012.00	0.00
RADIOLOGY THERAPEUTIC	5,832.00	0.00
OCCUPATIONAL THERAPY	6,420.00	0.00
SPEECH PATHOLOGY	1,371.00	0.00
RENAL DIALYSIS	49,516.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,410.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	83,587.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	109,866.00	39.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,307.00	0.00
AUDIOLOGY	38,320.00	320.00
CARDIOLOGY	125,586.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,478.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,669.20	0.00
OTHER LAB SERVICES	26,055.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	66,621.00	1,008.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	286.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	85,950.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	90.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,134.00

TOTAL ANCILLARY	9,510,944.96	100,504.86
TOTAL ACCOMODATIONS	3,430,045.00	162,090.00
TOTAL CHARGES	12,940,989.96	262,594.86

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,057.37	ADJUSTMENTS	0.00
COVERED CHARGES	18,803.37	CONTRACTUAL ALLOW	3,291.61
NON-COVERED CHARGES	254.00	TOTAL MEDICAID LIAB	15,511.76
		LESS: COB	15,511.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6	0	1,950.00	150.00
NURSERY CARE CHARGES	9	0	2,205.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	4,155.00	150.00
SPECIAL CARE SERVICES				
C C U	2	0	1,485.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	1,485.00	0.00
TOTAL ACCOMODATIONS	17	0	5,640.00	150.00

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,495.00	0.00
MED/SURG SUPPLY	1,617.37	0.00
LABORATORY-GENERAL	3,197.00	104.00
RADIOLOGY-DIAGNOSTIC	237.00	0.00
CT SCAN	862.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	224.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	2,588.00	0.00
LABOR/DELIVERY ROOM	322.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	849.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	150.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	96.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	64.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	160.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,163.37	104.00
TOTAL ACCOMODATIONS	5,640.00	150.00
TOTAL CHARGES	18,803.37	254.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,706,172.30	ADJUSTMENTS	230,309.40
COVERED CHARGES	7,250,190.54	CONTRACTUAL ALLOW	4,439,984.14
NON-COVERED CHARGES	455,981.76	TOTAL MEDICAID LIAB	2,810,206.40
		LESS: COB	3,944.88
		LESS: COPAYMENT	11,736.00
		REIMBURSEMENT	2,794,525.52
		ALL OTHER	2,600,633.24
		FEE SCHEDULE-LAB	192,749.56
		INJECTABLE DRUGS	1,142.72

TOTAL NUMBER OF CLAIMS 13,581

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	608,243.90	34,412.76
MED/SURG SUPPLY	500,223.40	15,787.68
LABORATORY-GENERAL	444.00	27,720.00
RADIOLOGY-DIAGNOSTIC	230,907.00	8,777.00
CT SCAN	322,613.00	16,044.00
PHYSICAL THERAPY	47,764.00	1,256.00
EKG/ECG	30,871.00	306.00
IV THERAPY	54,461.00	125.00
OPERATING ROOM	1,627,246.94	98,038.22
LABOR/DELIVERY ROOM	80,396.00	2,705.00
RESPIRATORY SERVICES	49,470.00	1,194.00
ANESTHESIA	370,642.00	1,572.00
GI SERVICES	58,626.00	11,710.00
EMERGENCY ROOM	1,180,012.00	32,380.00
RECOVERY ROOM	283,156.00	292.00
LABORATORY PATHOLOGIC	0.00	1,245.00
RADIOLOGY THERAPEUTIC	76,301.00	10,426.00
OCCUPATIONAL THERAPY	2,853.00	165.00
SPEECH PATHOLOGY	10,232.00	352.00
RENAL DIALYSIS	0.00	4,728.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	19,741.00	1,360.10
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	215,501.00	19,065.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,674.00	11,689.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	37,577.00	3,985.00
AUDIOLOGY	13,306.00	858.00
CARDIOLOGY	96,167.00	1,549.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	103,258.00	5,880.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	307,010.62	6,361.00
OTHER LAB SERVICES	18,281.00	392.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,708.00	874.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	724,380.68	123,466.00
MRI SERVICES	78,177.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	4,290.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	399.00	0.00
AMBULANCE	0.00	22.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,548.00	6,682.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	10.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	263.00

TOTAL ANCILLARY	7,250,190.54	455,981.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,250,190.54	455,981.76

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	21,946.50	ADJUSTMENTS	0.00
COVERED CHARGES	21,110.50	CONTRACTUAL ALLOW	5,650.66
NON-COVERED CHARGES	836.00	TOTAL MEDICAID LIAB	15,459.84
		LESS: COB	15,396.84
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	379.28-
		FEE SCHEDULE-LAB	379.28
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,320.00	15.00
MED/SURG SUPPLY	2,285.50	9.00
LABORATORY-GENERAL	0.00	111.00
RADIOLOGY-DIAGNOSTIC	298.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	56.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,480.00	0.00
LABOR/DELIVERY ROOM	720.00	0.00
RESPIRATORY SERVICES	46.00	0.00
ANESTHESIA	2,304.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,772.00	0.00
RECOVERY ROOM	1,035.00	0.00
LABORATORY PATHOLOGIC	0.00	47.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	79.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	96.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	64.00	323.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,483.00	331.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,110.50	836.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,110.50	836.00

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	291,896.64	ADJUSTMENTS	641.00
COVERED CHARGES	284,976.43	CONTRACTUAL ALLOW	218,264.75
NON-COVERED CHARGES	6,920.21	TOTAL MEDICAID LIAB	66,711.68
		LESS: COB	369.36
		LESS: COPAYMENT	1,467.00
		REIMBURSEMENT	64,875.32

TOTAL NUMBER OF CLAIMS 1,369

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,279.95	300.21
MED/SURG SUPPLY	7,311.28	298.00
LABORATORY-GENERAL	22,014.00	2,534.00
RADIOLOGY-DIAGNOSTIC	8,746.00	0.00
CT SCAN	8,185.00	373.00
PHYSICAL THERAPY	504.00	0.00
EKG/ECG	1,232.00	0.00
IV THERAPY	2,875.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,120.00	0.00
RESPIRATORY SERVICES	1,885.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	545.00	0.00
EMERGENCY ROOM	199,175.00	2,968.00
RECOVERY ROOM	292.00	0.00
LABORATORY PATHOLOGIC	455.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	420.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,815.00	447.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	166.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	367.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,050.20	0.00
OTHER LAB SERVICES	547.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	56.00	0.00
MRI SERVICES	1,008.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	762.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	284,976.43	6,920.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	284,976.43	6,920.21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,922.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,258.00	CONTRACTUAL ALLOW	908.85
NON-COVERED CHARGES	664.00	TOTAL MEDICAID LIAB	349.15
		LESS: COB	349.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.00	0.00
MED/SURG SUPPLY	46.00	0.00
LABORATORY-GENERAL	202.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	761.00	664.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,258.00	664.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,258.00	664.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	175,306.54	ADJUSTMENTS	3,959.98
COVERED CHARGES	168,037.99	CONTRACTUAL ALLOW	112,598.27
NON-COVERED CHARGES	7,268.55	TOTAL MEDICAID LIAB	55,439.72
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	55,415.72

TOTAL NUMBER OF CLAIMS 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,752.15	790.00
MED/SURG SUPPLY	19,168.00	65.00
LABORATORY-GENERAL	0.00	148.00
RADIOLOGY-DIAGNOSTIC	871.00	95.00
CT SCAN	1,534.00	0.00
PHYSICAL THERAPY	141.00	0.00
EKG/ECG	280.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	60,559.84	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	139.00	0.00
ANESTHESIA	10,312.00	576.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,050.00	120.00
RECOVERY ROOM	3,584.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	560.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,299.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	7,724.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	32.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,460.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,858.00	186.55
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,375.00	1,443.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	156.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,246.00	3,657.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	168,037.99	7,268.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,037.99	7,268.55

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,878,788.57	ADJUSTMENTS	343,346.24
COVERED CHARGES	12,637,326.37	CONTRACTUAL ALLOW	4,377,671.18
NON-COVERED CHARGES	241,462.20	TOTAL MEDICAID LIAB	8,259,655.19
		LESS: COB	127,229.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,132,425.34

TOTAL NUMBER OF ADMISSIONS 2,423

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,878	0	1,584,770.00	121,855.00
NURSERY CARE CHARGES	2,113	0	565,605.00	27,495.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	6,991	1	2,150,375.00	149,350.00
SPECIAL CARE SERVICES				
C C U	1,518	0	1,111,800.00	0.00
I C U	0	0	0.00	0.00
N I C U	34	11	19,720.00	6,380.00
PED I C U	26	0	16,510.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,578	11	1,148,030.00	6,380.00
TOTAL ACCOMODATIONS	8,569	12	3,298,405.00	155,730.00

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,281,425.44	8.32
MED/SURG SUPPLY	1,070,919.90	16,106.00
LABORATORY-GENERAL	1,248,688.00	49,648.00
RADIOLOGY-DIAGNOSTIC	167,329.00	0.00
CT SCAN	335,475.00	0.00
PHYSICAL THERAPY	54,943.00	0.00
EKG/ECG	36,870.00	0.00
IV THERAPY	37,010.00	0.00
OPERATING ROOM	1,469,384.14	0.00
LABOR/DELIVERY ROOM	703,516.00	0.00
RESPIRATORY SERVICES	581,154.70	0.00
ANESTHESIA	206,332.80	374.00
GI SERVICES	40,384.00	0.00
EMERGENCY ROOM	271,768.04	0.00
RECOVERY ROOM	79,050.00	0.00
LABORATORY PATHOLOGIC	144,289.00	296.30
RADIOLOGY THERAPEUTIC	7,429.00	0.00
OCCUPATIONAL THERAPY	2,508.00	0.00
SPEECH PATHOLOGY	925.00	0.00
RENAL DIALYSIS	67,672.00	160.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	403.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	7,724.00	0.00
OTHER IMAGING SERVICES	98,239.00	2,552.00
BLOOD	2,588.00	0.00
BLOOD STORAGE & PRO.	96,255.00	503.63
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,062.00	0.00
AUDIOLOGY	41,578.00	0.00
CARDIOLOGY	137,237.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,086.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,599.60	50.50
OTHER LAB SERVICES	20,268.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	70,428.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,783.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	659.45
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	14,971.00

TOTAL ANCILLARY	9,338,921.37	85,732.20
TOTAL ACCOMODATIONS	3,298,405.00	155,730.00
TOTAL CHARGES	12,637,326.37	241,462.20

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	59,682.35	ADJUSTMENTS	0.00
COVERED CHARGES	58,634.35	CONTRACTUAL ALLOW	2,554.79
NON-COVERED CHARGES	1,048.00	TOTAL MEDICAID LIAB	56,079.56
		LESS: COB	56,079.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	24	0	7,800.00	600.00
NURSERY CARE CHARGES	3	0	895.00	90.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27	0	8,695.00	690.00
SPECIAL CARE SERVICES				
C C U	1	0	635.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	635.00	0.00
TOTAL ACCOMODATIONS	28	0	9,330.00	690.00

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,445.45	0.00
MED/SURG SUPPLY	5,528.90	84.00
LABORATORY-GENERAL	5,321.00	274.00
RADIOLOGY-DIAGNOSTIC	765.00	0.00
CT SCAN	887.00	0.00
PHYSICAL THERAPY	141.00	0.00
EKG/ECG	168.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	18,065.00	0.00
LABOR/DELIVERY ROOM	3,066.00	0.00
RESPIRATORY SERVICES	515.00	0.00
ANESTHESIA	2,754.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,403.00	0.00
RECOVERY ROOM	345.00	0.00
LABORATORY PATHOLOGIC	1,113.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	60.00	0.00
CARDIOLOGY	412.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	49,304.35	358.00
TOTAL ACCOMODATIONS	9,330.00	690.00
TOTAL CHARGES	58,634.35	1,048.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,501,223.27	ADJUSTMENTS	465,157.37
COVERED CHARGES	8,239,890.58	CONTRACTUAL ALLOW	5,520,445.85
NON-COVERED CHARGES	261,332.69	TOTAL MEDICAID LIAB	2,719,444.73
		LESS: COB	3,976.71
		LESS: COPAYMENT	7,389.00
		REIMBURSEMENT	2,708,079.02
		ALL OTHER	2,468,321.23
		FEE SCHEDULE-LAB	239,753.03
		INJECTABLE DRUGS	4.76

TOTAL NUMBER OF CLAIMS 14,213

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	725,790.32	14,174.56
MED/SURG SUPPLY	522,447.80	3,601.00
LABORATORY-GENERAL	150.00	21,915.00
RADIOLOGY-DIAGNOSTIC	236,868.00	6,681.00
CT SCAN	441,706.00	5,735.00
PHYSICAL THERAPY	13,604.00	1,020.00
EKG/ECG	37,795.00	0.00
IV THERAPY	80,961.00	0.00
OPERATING ROOM	1,723,452.50	14,265.00
LABOR/DELIVERY ROOM	112,330.00	0.00
RESPIRATORY SERVICES	60,774.00	352.00
ANESTHESIA	377,658.00	1,246.00
GI SERVICES	51,312.00	0.00
EMERGENCY ROOM	1,388,444.41	669.00
RECOVERY ROOM	274,380.00	0.00
LABORATORY PATHOLOGIC	0.00	1,451.00
RADIOLOGY THERAPEUTIC	149,756.00	3,297.00
OCCUPATIONAL THERAPY	1,407.00	0.00
SPEECH PATHOLOGY	14,710.00	203.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	24,520.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	15,448.00	0.00
OTHER IMAGING SERVICES	256,654.00	9,215.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,325.00	8,269.63
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,118.00	5,524.00
AUDIOLOGY	23,487.00	367.00
CARDIOLOGY	111,171.00	399.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	171,069.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	401,766.80	280.00
OTHER LAB SERVICES	17,360.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,625.00	1,053.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	887,131.00	155,720.00
MRI SERVICES	57,666.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	806.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	985.00	22.50
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	172.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18.75	56.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	89.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,750.00

TOTAL ANCILLARY	8,239,890.58	261,332.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,239,890.58	261,332.69

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	40,470.20	ADJUSTMENTS	0.00
COVERED CHARGES	34,484.70	CONTRACTUAL ALLOW	2,820.69
NON-COVERED CHARGES	5,985.50	TOTAL MEDICAID LIAB	31,664.01
		LESS: COB	31,640.01
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	523.80-
		FEE SCHEDULE-LAB	523.80
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,140.10	0.00
MED/SURG SUPPLY	3,830.50	55.00
LABORATORY-GENERAL	0.00	1,288.00
RADIOLOGY-DIAGNOSTIC	650.00	378.00
CT SCAN	0.00	921.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	112.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	9,860.80	0.00
LABOR/DELIVERY ROOM	1,205.00	0.00
RESPIRATORY SERVICES	699.00	0.00
ANESTHESIA	1,888.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,502.00	0.00
RECOVERY ROOM	1,313.00	0.00
LABORATORY PATHOLOGIC	0.00	274.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	229.00	628.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	223.00	42.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,820.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,422.30	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	95.00	32.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,370.00	74.00
MRI SERVICES	0.00	1,008.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	277.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,008.00

TOTAL ANCILLARY	34,484.70	5,985.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,484.70	5,985.50

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	279,474.81	ADJUSTMENTS	4,936.56
COVERED CHARGES	276,716.40	CONTRACTUAL ALLOW	216,206.40
NON-COVERED CHARGES	2,758.41	TOTAL MEDICAID LIAB	60,510.00
		LESS: COB	257.68
		LESS: COPAYMENT	1,356.00
		REIMBURSEMENT	58,896.32

TOTAL NUMBER OF CLAIMS 1,243

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,816.75	161.41
MED/SURG SUPPLY	4,157.00	329.00
LABORATORY-GENERAL	26,058.00	2,153.00
RADIOLOGY-DIAGNOSTIC	9,598.00	79.00
CT SCAN	5,835.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	784.00	0.00
IV THERAPY	3,075.00	0.00
OPERATING ROOM	1,680.00	0.00
LABOR/DELIVERY ROOM	600.00	0.00
RESPIRATORY SERVICES	1,773.00	0.00
ANESTHESIA	696.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	198,808.00	36.00
RECOVERY ROOM	278.00	0.00
LABORATORY PATHOLOGIC	190.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,702.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,997.65	0.00
OTHER LAB SERVICES	637.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	276,716.40	2,758.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	276,716.40	2,758.41

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	526.00	ADJUSTMENTS	0.00
COVERED CHARGES	526.00	CONTRACTUAL ALLOW	163.95
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	362.05
		LESS: COB	362.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	58.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	468.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	526.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	526.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	239,981.94	ADJUSTMENTS	15,245.68
COVERED CHARGES	238,021.94	CONTRACTUAL ALLOW	172,983.24
NON-COVERED CHARGES	1,960.00	TOTAL MEDICAID LIAB	65,038.70
		LESS: COB	600.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	64,381.70

TOTAL NUMBER OF CLAIMS 17

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,404.62	0.00
MED/SURG SUPPLY	15,369.00	12.00
LABORATORY-GENERAL	0.00	216.00
RADIOLOGY-DIAGNOSTIC	1,028.00	0.00
CT SCAN	3,734.00	0.00
PHYSICAL THERAPY	414.00	414.00
EKG/ECG	168.00	0.00
IV THERAPY	250.00	0.00
OPERATING ROOM	73,636.82	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46.00	0.00
ANESTHESIA	8,212.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,140.00	0.00
RECOVERY ROOM	4,408.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	9,024.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,398.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	19,310.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32.00	16.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,114.50	0.00
OTHER LAB SERVICES	207.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,126.00	1,198.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	104.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	238,021.94	1,960.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	238,021.94	1,960.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,100,698.72	ADJUSTMENTS	207,568.21
COVERED CHARGES	10,714,560.73	CONTRACTUAL ALLOW	4,191,524.98
NON-COVERED CHARGES	386,137.99	TOTAL MEDICAID LIAB	6,523,035.75
		LESS: COB	31,017.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,492,018.41

TOTAL NUMBER OF ADMISSIONS 1,797

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,559	4	1,198,075.00	268,105.00
NURSERY CARE CHARGES	1,611	0	435,530.00	26,720.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	7	0.00	0.00
TOTAL ROUTINE	5,170	11	1,633,605.00	294,825.00
SPECIAL CARE SERVICES				
C C U	1,256	0	1,020,305.00	0.00
I C U	1	0	2,980.00	0.00
N I C U	0	18	0.00	10,440.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,257	18	1,023,285.00	10,440.00
TOTAL ACCOMODATIONS	6,427	29	2,656,890.00	305,265.00

INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,989,169.94	0.00
MED/SURG SUPPLY	912,039.42	3,434.00
LABORATORY-GENERAL	1,166,745.50	25,160.00
RADIOLOGY-DIAGNOSTIC	137,128.00	0.00
CT SCAN	314,121.00	0.00
PHYSICAL THERAPY	45,869.00	0.00
EKG/ECG	36,323.00	0.00
IV THERAPY	52,435.00	0.00
OPERATING ROOM	1,175,974.75	0.00
LABOR/DELIVERY ROOM	515,632.00	0.00
RESPIRATORY SERVICES	479,615.00	0.00
ANESTHESIA	150,122.00	0.00
GI SERVICES	39,487.00	0.00
EMERGENCY ROOM	250,224.68	0.00
RECOVERY ROOM	59,296.00	0.00
LABORATORY PATHOLOGIC	109,069.00	1,892.00
RADIOLOGY THERAPEUTIC	1,407.00	0.00
OCCUPATIONAL THERAPY	4,951.00	0.00
SPEECH PATHOLOGY	937.00	0.00
RENAL DIALYSIS	63,352.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	241.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	73,796.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	88,546.13	1,717.89
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,032.00	0.00
AUDIOLOGY	25,560.00	0.00
CARDIOLOGY	152,493.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,462.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	44,242.45	0.00
OTHER LAB SERVICES	64,597.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	53,608.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	15.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,435.36	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,896.20
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	46,516.90

TOTAL ANCILLARY	8,057,670.73	80,872.99
TOTAL ACCOMODATIONS	2,656,890.00	305,265.00
TOTAL CHARGES	10,714,560.73	386,137.99

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,957.78	ADJUSTMENTS	0.00
COVERED CHARGES	16,711.78	CONTRACTUAL ALLOW	2,391.76
NON-COVERED CHARGES	246.00	TOTAL MEDICAID LIAB	14,320.02
		LESS: COB	14,320.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6	0	1,950.00	150.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	1,950.00	150.00
SPECIAL CARE SERVICES				
C C U	3	0	1,905.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,905.00	0.00
TOTAL ACCOMODATIONS	9	0	3,855.00	150.00

ZERO PAID INPATIENT PAID CLAIMS

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,793.90	0.00
MED/SURG SUPPLY	918.88	0.00
LABORATORY-GENERAL	1,551.00	96.00
RADIOLOGY-DIAGNOSTIC	424.00	0.00
CT SCAN	2,099.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	56.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	3,697.00	0.00
RESPIRATORY SERVICES	47.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	383.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	450.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	158.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,113.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,856.78	96.00
TOTAL ACCOMODATIONS	3,855.00	150.00
TOTAL CHARGES	16,711.78	246.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,649,435.61	ADJUSTMENTS	237,101.25
COVERED CHARGES	7,299,190.01	CONTRACTUAL ALLOW	5,148,409.48
NON-COVERED CHARGES	350,245.60	TOTAL MEDICAID LIAB	2,150,780.53
		LESS: COB	2,322.04
		LESS: COPAYMENT	9,219.00
		REIMBURSEMENT	2,139,239.49
		ALL OTHER	1,913,760.37
		FEE SCHEDULE-LAB	225,454.40
		INJECTABLE DRUGS	24.72

TOTAL NUMBER OF CLAIMS 11,712

OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	619,977.73	8,570.46
MED/SURG SUPPLY	371,987.64	2,545.00
LABORATORY-GENERAL	0.00	16,845.00
RADIOLOGY-DIAGNOSTIC	203,580.00	9,043.00
CT SCAN	376,297.00	26,423.00
PHYSICAL THERAPY	27,755.00	4,521.00
EKG/ECG	38,490.00	0.00
IV THERAPY	107,324.00	0.00
OPERATING ROOM	1,457,318.59	71,470.00
LABOR/DELIVERY ROOM	97,689.00	320.00
RESPIRATORY SERVICES	56,177.00	579.00
ANESTHESIA	306,061.00	1,822.00
GI SERVICES	77,175.00	1,033.00
EMERGENCY ROOM	1,125,936.50	1,360.00
RECOVERY ROOM	217,184.00	1,035.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	147,615.00	1,600.00
OCCUPATIONAL THERAPY	510.00	0.00
SPEECH PATHOLOGY	11,511.00	318.00
RENAL DIALYSIS	0.00	464.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	20,541.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,033.00	0.00
OTHER IMAGING SERVICES	186,410.50	10,399.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,433.00	6,775.63
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	50,226.00	1,890.00
AUDIOLOGY	9,272.00	121.00
CARDIOLOGY	116,007.00	1,078.36
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	234,787.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	416,816.90	3,437.70
OTHER LAB SERVICES	66,792.00	376.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,475.50	545.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	873,681.15	162,575.20
MRI SERVICES	56,780.00	2,056.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	1,110.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	263.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	83.50	4,204.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	507.25
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,222.00

TOTAL ANCILLARY	7,299,190.01	350,245.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,299,190.01	350,245.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	28,012.50	ADJUSTMENTS	0.00
COVERED CHARGES	21,221.00	CONTRACTUAL ALLOW	1,009.95
NON-COVERED CHARGES	6,791.50	TOTAL MEDICAID LIAB	20,211.05
		LESS: COB	20,193.05
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	809.63-
		FEE SCHEDULE-LAB	812.63
		INJECTABLE DRUGS	3.00-

TOTAL NUMBER OF CLAIMS 43

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,399.00	0.00
MED/SURG SUPPLY	1,080.00	0.00
LABORATORY-GENERAL	0.00	396.00
RADIOLOGY-DIAGNOSTIC	79.00	186.00
CT SCAN	2,468.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	56.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	3,465.00	0.00
LABOR/DELIVERY ROOM	120.00	0.00
RESPIRATORY SERVICES	47.00	0.00
ANESTHESIA	892.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,192.00	37.00
RECOVERY ROOM	623.00	0.00
LABORATORY PATHOLOGIC	0.00	150.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	376.00	169.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	210.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	244.00
AUDIOLOGY	2,385.00	144.00
CARDIOLOGY	412.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,051.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,240.50	853.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,612.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,221.00	6,791.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,221.00	6,791.50

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	319,116.65	ADJUSTMENTS	1,872.40
COVERED CHARGES	314,874.56	CONTRACTUAL ALLOW	256,290.56
NON-COVERED CHARGES	4,242.09	TOTAL MEDICAID LIAB	58,584.00
		LESS: COB	157.88
		LESS: COPAYMENT	1,587.00
		REIMBURSEMENT	56,839.12

TOTAL NUMBER OF CLAIMS 1,177

OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,469.50	75.59
MED/SURG SUPPLY	4,568.41	650.00
LABORATORY-GENERAL	37,067.00	3,232.50
RADIOLOGY-DIAGNOSTIC	12,157.00	79.00
CT SCAN	8,321.00	0.00
PHYSICAL THERAPY	146.00	0.00
EKG/ECG	1,094.00	0.00
IV THERAPY	6,850.00	0.00
OPERATING ROOM	2,486.00	0.00
LABOR/DELIVERY ROOM	428.00	0.00
RESPIRATORY SERVICES	2,206.00	0.00
ANESTHESIA	446.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	210,850.00	109.00
RECOVERY ROOM	345.00	0.00
LABORATORY PATHOLOGIC	94.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,797.00	96.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,156.15	0.00
OTHER LAB SERVICES	376.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	314,874.56	4,242.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	314,874.56	4,242.09

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,391.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,023.25	CONTRACTUAL ALLOW	881.85
NON-COVERED CHARGES	368.00	TOTAL MEDICAID LIAB	141.40
		LESS: COB	141.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140.25	8.00
MED/SURG SUPPLY	53.00	0.00
LABORATORY-GENERAL	153.00	20.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	47.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	630.00	340.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,023.25	368.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,023.25	368.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD

LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	255,740.67	ADJUSTMENTS	20,278.44
COVERED CHARGES	248,278.02	CONTRACTUAL ALLOW	183,872.96
NON-COVERED CHARGES	7,462.65	TOTAL MEDICAID LIAB	64,405.06
		LESS: COB	0.00
		LESS: COPAYMENT	198.00
		REIMBURSEMENT	64,207.06

TOTAL NUMBER OF CLAIMS 19

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH00236A

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,506.27	4,547.50
MED/SURG SUPPLY	34,568.82	0.00
LABORATORY-GENERAL	0.00	124.00
RADIOLOGY-DIAGNOSTIC	2,348.00	297.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	232.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	53,138.88	104.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	47.00	0.00
ANESTHESIA	4,790.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,035.00	0.00
RECOVERY ROOM	3,229.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	19,491.00	612.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,872.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	582.00	342.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,768.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,686.05	565.15
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	37,984.00	559.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	312.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	248,278.02	7,462.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	248,278.02	7,462.65

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LAGRANGE-TROUP CTY. HOSP. AUTHORITY
1514 VERNON RD
LAGRANGE GA 30240-4131

PROVIDER NUMBER 000002065A
NUMBER OF BEDS 5
TITLE XVIII NO: HPH00236A

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,151,321.07	ADJUSTMENTS	0.00
COVERED CHARGES	1,151,321.07	CONTRACTUAL ALLOW	683,783.47
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	467,537.60
		LESS: COB	16,101.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	451,436.10

TOTAL NUMBER OF ADMISSIONS 107

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	419	0	131,985.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	419	0	131,985.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	419	0	131,985.00	0.00

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,689.29	0.00
MED/SURG SUPPLY	183,904.78	0.00
LABORATORY-GENERAL	233,416.00	0.00
RADIOLOGY-DIAGNOSTIC	26,887.00	0.00
CT SCAN	64,904.00	0.00
PHYSICAL THERAPY	1,913.00	0.00
EKG/ECG	14,586.00	0.00
IV THERAPY	3,536.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33,354.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	6,412.00	0.00
EMERGENCY ROOM	35,977.00	0.00
RECOVERY ROOM	987.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,769.00	0.00
BLOOD	3,926.00	0.00
BLOOD STORAGE & PRO.	6,214.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,879.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,895.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,194.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,301.00	0.00
OTHER LAB SERVICES	17,221.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,074.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	297.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,019,336.07	0.00
TOTAL ACCOMODATIONS	131,985.00	0.00
TOTAL CHARGES	1,151,321.07	0.00

ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,631,268.76	ADJUSTMENTS	949.20
COVERED CHARGES	1,484,769.06	CONTRACTUAL ALLOW	405,820.87
NON-COVERED CHARGES	146,499.70	TOTAL MEDICAID LIAB	1,078,948.19
		LESS: COB	1,453.40
		LESS: COPAYMENT	4,488.00
		REIMBURSEMENT	1,073,006.79
		ALL OTHER	1,033,545.81
		FEE SCHEDULE-LAB	38,000.28
		INJECTABLE DRUGS	1,460.70

TOTAL NUMBER OF CLAIMS 2,640

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,848.75	1,618.00
MED/SURG SUPPLY	95,057.01	335.50
LABORATORY-GENERAL	0.00	22,816.00
RADIOLOGY-DIAGNOSTIC	145,577.00	5,019.50
CT SCAN	154,986.00	7,873.00
PHYSICAL THERAPY	44,597.00	610.00
EKG/ECG	18,004.00	448.00
IV THERAPY	15,132.00	408.00
OPERATING ROOM	4,837.00	3,486.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,438.00	579.00
ANESTHESIA	0.00	0.00
GI SERVICES	28,382.00	1,452.00
EMERGENCY ROOM	217,673.00	818.00
RECOVERY ROOM	8,357.00	141.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	42,310.00	250.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,899.00	424.00
BLOOD	180.00	0.00
BLOOD STORAGE & PRO.	100.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,644.00	1,375.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30,247.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	597.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,066.00	3,472.00
OTHER LAB SERVICES	47,798.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	328,160.30	91,940.70
MRI SERVICES	84,146.00	3,388.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,733.00	46.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,484,769.06	146,499.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,484,769.06	146,499.70

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,422.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,083.00	CONTRACTUAL ALLOW	949.92
NON-COVERED CHARGES	2,339.00	TOTAL MEDICAID LIAB	6,133.08
		LESS: COB	6,112.08
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	344.36-
		FEE SCHEDULE-LAB	344.36
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.00	0.00
MED/SURG SUPPLY	64.00	0.00
LABORATORY-GENERAL	0.00	38.00
RADIOLOGY-DIAGNOSTIC	605.00	247.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	151.00	0.00
IV THERAPY	272.00	0.00
OPERATING ROOM	0.00	1,600.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	58.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	764.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,001.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,083.00	454.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,083.00	2,339.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,083.00	2,339.00

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	164,593.65	ADJUSTMENTS	0.00
COVERED CHARGES	160,422.65	CONTRACTUAL ALLOW	136,730.65
NON-COVERED CHARGES	4,171.00	TOTAL MEDICAID LIAB	23,692.00
		LESS: COB	0.00
		LESS: COPAYMENT	471.00
		REIMBURSEMENT	23,221.00

TOTAL NUMBER OF CLAIMS 477

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,621.70	93.00
MED/SURG SUPPLY	3,075.95	0.00
LABORATORY-GENERAL	20,332.00	3,452.00
RADIOLOGY-DIAGNOSTIC	11,332.00	231.00
CT SCAN	3,174.00	0.00
PHYSICAL THERAPY	0.00	171.00
EKG/ECG	750.00	0.00
IV THERAPY	408.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,986.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	97,463.00	224.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	330.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	154.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	330.00	0.00
OTHER LAB SERVICES	78.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,388.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	160,422.65	4,171.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	160,422.65	4,171.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,440.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,868.00	CONTRACTUAL ALLOW	769.52
NON-COVERED CHARGES	572.00	TOTAL MEDICAID LIAB	1,098.48
		LESS: COB	1,098.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.00	193.00
MED/SURG SUPPLY	0.00	7.00
LABORATORY-GENERAL	630.00	63.00
RADIOLOGY-DIAGNOSTIC	139.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	136.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	116.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	742.00	309.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,868.00	572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,868.00	572.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	366,243.22	ADJUSTMENTS	0.00
COVERED CHARGES	347,240.22	CONTRACTUAL ALLOW	158,771.49
NON-COVERED CHARGES	19,003.00	TOTAL MEDICAID LIAB	188,468.73
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	188,357.73

TOTAL NUMBER OF CLAIMS 50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,193.57	0.00
MED/SURG SUPPLY	56,121.25	0.00
LABORATORY-GENERAL	0.00	2,024.00
RADIOLOGY-DIAGNOSTIC	6,250.00	517.00
CT SCAN	51,684.00	0.00
PHYSICAL THERAPY	0.00	640.00
EKG/ECG	4,847.00	560.00
IV THERAPY	1,632.00	0.00
OPERATING ROOM	2,456.00	2,166.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,169.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,079.00	0.00
RECOVERY ROOM	705.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,810.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,275.00	1,100.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,297.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55,049.40	1,001.00
OTHER LAB SERVICES	4,283.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,987.00	10,995.00
MRI SERVICES	22,402.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	347,240.22	19,003.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	347,240.22	19,003.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	860,590.00	ADJUSTMENTS	0.00
COVERED CHARGES	857,289.00	CONTRACTUAL ALLOW	524,184.22
NON-COVERED CHARGES	3,301.00	TOTAL MEDICAID LIAB	333,104.78
		LESS: COB	4,209.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	328,895.19

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	293	0	92,295.00	630.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	293	0	92,295.00	630.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	293	0	92,295.00	630.00

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255,949.50	0.00
MED/SURG SUPPLY	134,593.50	0.00
LABORATORY-GENERAL	145,473.00	0.00
RADIOLOGY-DIAGNOSTIC	22,245.00	0.00
CT SCAN	73,859.00	0.00
PHYSICAL THERAPY	1,720.50	0.00
EKG/ECG	7,869.00	0.00
IV THERAPY	3,130.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,867.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,870.00	0.00
EMERGENCY ROOM	27,969.50	0.00
RECOVERY ROOM	486.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	245.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,890.50	0.00
BLOOD	9,060.00	0.00
BLOOD STORAGE & PRO.	5,412.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,427.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,381.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,850.00	0.00
OTHER LAB SERVICES	14,726.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,948.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,022.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,671.00

TOTAL ANCILLARY	764,994.00	2,671.00
TOTAL ACCOMODATIONS	92,295.00	630.00
TOTAL CHARGES	857,289.00	3,301.00

ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,213.50	ADJUSTMENTS	0.00
COVERED CHARGES	13,213.50	CONTRACTUAL ALLOW	3,205.87
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	10,007.63
		LESS: COB	10,007.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10	0	3,150.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	3,150.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	10	0	3,150.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,009.00	0.00
MED/SURG SUPPLY	1,580.50	0.00
LABORATORY-GENERAL	3,018.00	0.00
RADIOLOGY-DIAGNOSTIC	320.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	136.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,063.50	0.00
TOTAL ACCOMODATIONS	3,150.00	0.00
TOTAL CHARGES	13,213.50	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,393,760.16	ADJUSTMENTS	5,951.49
COVERED CHARGES	1,272,532.66	CONTRACTUAL ALLOW	328,775.51
NON-COVERED CHARGES	121,227.50	TOTAL MEDICAID LIAB	943,757.15
		LESS: COB	11,115.31
		LESS: COPAYMENT	3,423.00
		REIMBURSEMENT	929,218.84
		ALL OTHER	900,724.43
		FEE SCHEDULE-LAB	28,494.41
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,168

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,914.00	659.50
MED/SURG SUPPLY	78,012.16	725.50
LABORATORY-GENERAL	0.00	6,614.00
RADIOLOGY-DIAGNOSTIC	123,911.00	2,023.00
CT SCAN	139,224.00	3,578.50
PHYSICAL THERAPY	38,376.00	401.50
EKG/ECG	10,195.50	1,161.00
IV THERAPY	17,997.50	0.00
OPERATING ROOM	2,124.50	3,491.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27,037.50	649.00
ANESTHESIA	0.00	0.00
GI SERVICES	26,580.00	1,670.00
EMERGENCY ROOM	189,714.00	768.00
RECOVERY ROOM	8,263.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	735.00	0.00
SPEECH PATHOLOGY	0.00	592.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	61,610.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,331.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,574.00	316.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,870.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	686.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,145.00	0.00
OTHER LAB SERVICES	36,626.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	245,456.00	83,633.50
MRI SERVICES	74,261.00	1,948.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	90.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	11,490.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	2,799.00	246.00

TOTAL ANCILLARY	1,272,532.66	119,967.50
TOTAL ACCOMODATIONS	0.00	1,260.00
TOTAL CHARGES	1,272,532.66	121,227.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,047.50	ADJUSTMENTS	0.00
COVERED CHARGES	18,373.00	CONTRACTUAL ALLOW	1,725.49
NON-COVERED CHARGES	674.50	TOTAL MEDICAID LIAB	16,647.51
		LESS: COB	16,617.51
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	284.69-
		FEE SCHEDULE-LAB	284.69
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	451.50	0.00
MED/SURG SUPPLY	488.00	0.00
LABORATORY-GENERAL	0.00	19.00
RADIOLOGY-DIAGNOSTIC	1,204.00	138.00
CT SCAN	7,985.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	426.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	270.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,462.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,460.00	247.00
MRI SERVICES	3,896.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,373.00	674.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,373.00	674.50

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	143,398.00	ADJUSTMENTS	47.00
COVERED CHARGES	139,136.50	CONTRACTUAL ALLOW	124,191.50
NON-COVERED CHARGES	4,261.50	TOTAL MEDICAID LIAB	14,945.00
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	14,609.00

TOTAL NUMBER OF CLAIMS 299

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,617.00	0.00
MED/SURG SUPPLY	5,832.50	0.00
LABORATORY-GENERAL	14,550.00	2,126.00
RADIOLOGY-DIAGNOSTIC	8,006.50	549.50
CT SCAN	5,764.00	1,311.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,294.50	0.00
IV THERAPY	939.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,784.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	69,716.00	271.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	360.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	487.50	3.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,851.00	0.00
OTHER LAB SERVICES	934.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	139,136.50	4,261.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	139,136.50	4,261.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	566.00	ADJUSTMENTS	0.00
COVERED CHARGES	566.00	CONTRACTUAL ALLOW	84.37
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	481.63
		LESS: COB	478.63
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62.00	0.00
MED/SURG SUPPLY	90.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	414.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	566.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	566.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	403,129.00	ADJUSTMENTS	0.00
COVERED CHARGES	341,167.00	CONTRACTUAL ALLOW	166,165.71
NON-COVERED CHARGES	61,962.00	TOTAL MEDICAID LIAB	175,001.29
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	174,938.29

TOTAL NUMBER OF CLAIMS 47

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,086.50	0.00
MED/SURG SUPPLY	55,564.50	0.00
LABORATORY-GENERAL	0.00	4,004.00
RADIOLOGY-DIAGNOSTIC	7,951.50	1,158.50
CT SCAN	42,173.00	5,516.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,531.00	1,548.00
IV THERAPY	2,347.50	0.00
OPERATING ROOM	607.00	1,134.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,201.00	1,234.50
ANESTHESIA	0.00	0.00
GI SERVICES	2,365.00	835.00
EMERGENCY ROOM	15,189.50	0.00
RECOVERY ROOM	2,016.00	162.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,462.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,130.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,739.50	2,280.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,890.50	797.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	34,417.00	11,424.00
OTHER LAB SERVICES	11,516.50	45.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,030.50	27,713.50
MRI SERVICES	1,948.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	341,167.00	57,852.00
TOTAL ACCOMODATIONS	0.00	4,110.00
TOTAL CHARGES	341,167.00	61,962.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,826.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,582.00	CONTRACTUAL ALLOW	1,141.20
NON-COVERED CHARGES	244.00	TOTAL MEDICAID LIAB	4,440.80
		LESS: COB	4,440.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	896.00	0.00
MED/SURG SUPPLY	116.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124.00	0.00
CT SCAN	1,938.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	483.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	487.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	840.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	697.00	244.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,582.00	244.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,582.00	244.00

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	688,360.45	ADJUSTMENTS	0.00
COVERED CHARGES	685,413.45	CONTRACTUAL ALLOW	379,066.30
NON-COVERED CHARGES	2,947.00	TOTAL MEDICAID LIAB	306,347.15
		LESS: COB	1,945.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	304,401.41

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	248	0	79,140.00	2,700.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	248	0	79,140.00	2,700.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	248	0	79,140.00	2,700.00

INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215,114.80	0.00
MED/SURG SUPPLY	92,837.65	0.00
LABORATORY-GENERAL	127,288.50	0.00
RADIOLOGY-DIAGNOSTIC	16,562.00	0.00
CT SCAN	61,484.50	0.00
PHYSICAL THERAPY	571.00	0.00
EKG/ECG	8,415.00	0.00
IV THERAPY	3,130.00	0.00
OPERATING ROOM	911.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,141.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	835.00	0.00
EMERGENCY ROOM	23,638.50	0.00
RECOVERY ROOM	324.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,569.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,430.00	247.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,058.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,057.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,226.00	0.00
OTHER LAB SERVICES	8,358.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,896.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	426.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	606,273.45	247.00
TOTAL ACCOMODATIONS	79,140.00	2,700.00
TOTAL CHARGES	685,413.45	2,947.00

ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,124,224.45	ADJUSTMENTS	234.12
COVERED CHARGES	996,111.45	CONTRACTUAL ALLOW	377,280.62
NON-COVERED CHARGES	128,113.00	TOTAL MEDICAID LIAB	618,830.83
		LESS: COB	414.45
		LESS: COPAYMENT	1,947.00
		REIMBURSEMENT	616,469.38
		ALL OTHER	594,098.45
		FEE SCHEDULE-LAB	22,370.93
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,392

OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,820.90	2,873.50
MED/SURG SUPPLY	69,798.45	86.50
LABORATORY-GENERAL	0.00	576.00
RADIOLOGY-DIAGNOSTIC	87,187.50	1,709.00
CT SCAN	86,109.50	13,423.50
PHYSICAL THERAPY	17,620.00	3,719.00
EKG/ECG	9,373.50	1,080.00
IV THERAPY	16,029.50	1,878.00
OPERATING ROOM	3,035.00	1,973.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,567.50	835.50
ANESTHESIA	0.00	0.00
GI SERVICES	31,660.00	2,505.00
EMERGENCY ROOM	140,154.50	5,507.00
RECOVERY ROOM	9,234.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	16,010.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,846.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	630.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,985.00	1,266.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,691.50	1,151.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,432.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	41,274.60	2,366.00
OTHER LAB SERVICES	14,897.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	206,029.00	80,605.50
MRI SERVICES	49,625.00	5,844.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	100.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	294.50
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	37.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	226.50

TOTAL ANCILLARY	996,111.45	127,956.50
TOTAL ACCOMODATIONS	0.00	156.50
TOTAL CHARGES	996,111.45	128,113.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,777.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,397.50	CONTRACTUAL ALLOW	1,334.53
NON-COVERED CHARGES	1,379.50	TOTAL MEDICAID LIAB	6,062.97
		LESS: COB	6,053.97
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	387.60-
		FEE SCHEDULE-LAB	387.60
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	614.50	116.50
MED/SURG SUPPLY	767.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	556.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	129.00	0.00
IV THERAPY	313.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	412.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,488.50	729.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	45.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,071.00	534.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,397.50	1,379.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,397.50	1,379.50

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	152,110.20	ADJUSTMENTS	100.00
COVERED CHARGES	147,293.20	CONTRACTUAL ALLOW	131,793.20
NON-COVERED CHARGES	4,817.00	TOTAL MEDICAID LIAB	15,500.00
		LESS: COB	21.37
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	15,121.63

TOTAL NUMBER OF CLAIMS 310

OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,935.50	0.00
MED/SURG SUPPLY	2,514.70	0.00
LABORATORY-GENERAL	24,772.00	2,837.00
RADIOLOGY-DIAGNOSTIC	12,431.00	0.00
CT SCAN	5,172.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,290.00	0.00
IV THERAPY	626.00	313.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,347.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	67,202.00	516.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	487.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,151.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	380.00	0.00
OTHER LAB SERVICES	135.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	147,293.20	4,817.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,293.20	4,817.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,422.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,756.50	CONTRACTUAL ALLOW	3,756.50
NON-COVERED CHARGES	1,665.50	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	749.00	104.00
MED/SURG SUPPLY	43.00	0.00
LABORATORY-GENERAL	512.00	129.00
RADIOLOGY-DIAGNOSTIC	124.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	532.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,561.50	1,432.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	190.00	0.00
OTHER LAB SERVICES	45.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,756.50	1,665.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,756.50	1,665.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	366,379.56	ADJUSTMENTS	0.00
COVERED CHARGES	296,776.06	CONTRACTUAL ALLOW	158,023.66
NON-COVERED CHARGES	69,603.50	TOTAL MEDICAID LIAB	138,752.40
		LESS: COB	0.00
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	138,686.40

TOTAL NUMBER OF CLAIMS 43

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP177

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,512.20	0.00
MED/SURG SUPPLY	45,863.00	0.00
LABORATORY-GENERAL	0.00	15,159.00
RADIOLOGY-DIAGNOSTIC	5,921.00	4,085.00
CT SCAN	24,712.00	8,051.50
PHYSICAL THERAPY	0.00	326.50
EKG/ECG	3,936.00	2,064.00
IV THERAPY	2,504.00	156.50
OPERATING ROOM	0.00	2,004.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,311.50	270.00
ANESTHESIA	0.00	0.00
GI SERVICES	2,365.00	0.00
EMERGENCY ROOM	13,527.00	0.00
RECOVERY ROOM	324.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	129.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,629.50	487.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,170.00	3,165.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,452.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,212.36	6,202.00
OTHER LAB SERVICES	4,622.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,130.00	19,583.00
MRI SERVICES	15,584.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	296,776.06	61,683.50
TOTAL ACCOMODATIONS	0.00	7,920.00
TOTAL CHARGES	296,776.06	69,603.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONEE HOSPITAL, INC
111 N. THIRD STREET
GLENWOOD GA 30428-9004

PROVIDER NUMBER 000002076A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP177

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,326,184.49	ADJUSTMENTS	653.96
COVERED CHARGES	1,281,103.66	CONTRACTUAL ALLOW	541,287.53
NON-COVERED CHARGES	45,080.83	TOTAL MEDICAID LIAB	739,816.13
		LESS: COB	2,594.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	737,221.88

TOTAL NUMBER OF ADMISSIONS 221

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	484	0	154,880.00	17,520.00
NURSERY CARE CHARGES	114	0	25,845.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	598	0	180,725.00	17,520.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	87	0	83,640.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	87	0	83,640.00	0.00
TOTAL ACCOMODATIONS	685	0	264,365.00	17,520.00

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,589.90	0.00
MED/SURG SUPPLY	137,406.40	0.00
LABORATORY-GENERAL	115,453.00	97.00
RADIOLOGY-DIAGNOSTIC	18,063.00	0.00
CT SCAN	22,477.00	0.00
PHYSICAL THERAPY	4,940.00	0.00
EKG/ECG	6,934.00	0.00
IV THERAPY	7,250.00	0.00
OPERATING ROOM	62,914.00	0.00
LABOR/DELIVERY ROOM	97,530.00	0.00
RESPIRATORY SERVICES	104,241.00	0.00
ANESTHESIA	11,875.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,373.00	0.00
RECOVERY ROOM	3,537.00	0.00
LABORATORY PATHOLOGIC	5,221.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,184.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	10,400.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,153.54
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,321.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,531.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,260.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,041.00	1,813.00
OTHER LAB SERVICES	901.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	18,960.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,296.36	5,537.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,016,738.66	27,560.83
TOTAL ACCOMODATIONS	264,365.00	17,520.00
TOTAL CHARGES	1,281,103.66	45,080.83

ZERO PAID INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,167,528.05	ADJUSTMENTS	29,822.67
COVERED CHARGES	1,074,371.55	CONTRACTUAL ALLOW	539,732.77
NON-COVERED CHARGES	93,156.50	TOTAL MEDICAID LIAB	534,638.78
		LESS: COB	1,149.72
		LESS: COPAYMENT	2,013.00
		REIMBURSEMENT	531,476.06
		ALL OTHER	495,437.09
		FEE SCHEDULE-LAB	34,649.69
		INJECTABLE DRUGS	1,389.28

TOTAL NUMBER OF CLAIMS 2,807

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,212.95	8,497.71
MED/SURG SUPPLY	60,416.80	3,869.00
LABORATORY-GENERAL	234.00	2,403.00
RADIOLOGY-DIAGNOSTIC	95,627.00	4,369.00
CT SCAN	84,214.00	0.00
PHYSICAL THERAPY	16,213.00	3,792.00
EKG/ECG	12,532.00	0.00
IV THERAPY	23,375.00	0.00
OPERATING ROOM	135,101.00	21,474.00
LABOR/DELIVERY ROOM	8,250.00	0.00
RESPIRATORY SERVICES	18,742.00	914.00
ANESTHESIA	650.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	206,964.00	7,080.00
RECOVERY ROOM	15,327.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,054.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	42,087.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,815.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,533.00	1,167.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,712.00	3,256.00
OTHER LAB SERVICES	4,087.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	153,400.90	29,244.70
MRI SERVICES	45,087.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,551.90	5,275.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,074,371.55	93,156.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,074,371.55	93,156.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,605.50	ADJUSTMENTS	0.00
COVERED CHARGES	17,918.50	CONTRACTUAL ALLOW	5,584.00
NON-COVERED CHARGES	687.00	TOTAL MEDICAID LIAB	12,334.50
		LESS: COB	12,322.50
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	383.16-
		FEE SCHEDULE-LAB	382.89
		INJECTABLE DRUGS	0.27

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	705.00	0.00
MED/SURG SUPPLY	809.00	0.00
LABORATORY-GENERAL	0.00	53.00
RADIOLOGY-DIAGNOSTIC	856.00	0.00
CT SCAN	1,794.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	268.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	3,545.00	0.00
LABOR/DELIVERY ROOM	950.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,150.00	200.00
RECOVERY ROOM	524.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	63.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,208.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,180.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	253.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,688.00	355.00
MRI SERVICES	2,800.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.50	79.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,918.50	687.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,918.50	687.00

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	66,244.25	ADJUSTMENTS	1,561.20
COVERED CHARGES	62,119.59	CONTRACTUAL ALLOW	42,169.59
NON-COVERED CHARGES	4,124.66	TOTAL MEDICAID LIAB	19,950.00
		LESS: COB	87.20
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	19,589.80

TOTAL NUMBER OF CLAIMS 399

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,818.92	557.55
MED/SURG SUPPLY	1,213.00	30.00
LABORATORY-GENERAL	7,456.00	1,161.00
RADIOLOGY-DIAGNOSTIC	3,705.00	794.00
CT SCAN	1,227.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	392.00	0.00
IV THERAPY	1,875.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,225.00	1,095.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	650.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	532.67	487.11
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	62,119.59	4,124.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,119.59	4,124.66

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,509.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,242.00	CONTRACTUAL ALLOW	268.16
NON-COVERED CHARGES	267.00	TOTAL MEDICAID LIAB	973.84
		LESS: COB	973.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	562.00	0.00
MED/SURG SUPPLY	46.00	0.00
LABORATORY-GENERAL	147.00	7.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	125.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	420.00	135.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	67.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,242.00	267.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,242.00	267.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	16,644.27	ADJUSTMENTS	0.00
COVERED CHARGES	15,871.27	CONTRACTUAL ALLOW	11,937.76
NON-COVERED CHARGES	773.00	TOTAL MEDICAID LIAB	3,933.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,933.51

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,874.27	0.00
MED/SURG SUPPLY	6,846.00	0.00
LABORATORY-GENERAL	238.00	24.00
RADIOLOGY-DIAGNOSTIC	167.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	98.00	0.00
IV THERAPY	125.00	0.00
OPERATING ROOM	2,034.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,367.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	600.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	37.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,085.00	149.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	15,871.27	773.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,871.27	773.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
120 GORDON ST	000002087A	56	SERVICE DATES 05/01/2004 THROUGH 04/30/2005
	TITLE XVIII NO: 111325		
WASHINGTON GA 30673-1602			

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	582,433.34	ADJUSTMENTS	0.00
COVERED CHARGES	570,779.38	CONTRACTUAL ALLOW	224,833.14
NON-COVERED CHARGES	11,653.96	TOTAL MEDICAID LIAB	345,946.24
		LESS: COB	6,345.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	339,600.56

TOTAL NUMBER OF ADMISSIONS 101

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	219	0	75,030.00	4,090.00
NURSERY CARE CHARGES	34	0	7,820.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	253	0	82,850.00	4,090.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	52	0	50,960.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	52	0	50,960.00	0.00
TOTAL ACCOMODATIONS	305	0	133,810.00	4,090.00

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162,871.19	0.00
MED/SURG SUPPLY	54,680.00	45.00
LABORATORY-GENERAL	54,404.00	49.00
RADIOLOGY-DIAGNOSTIC	8,340.00	0.00
CT SCAN	15,469.00	0.00
PHYSICAL THERAPY	2,885.00	0.00
EKG/ECG	4,470.00	0.00
IV THERAPY	4,750.00	0.00
OPERATING ROOM	27,150.00	0.00
LABOR/DELIVERY ROOM	21,795.00	0.00
RESPIRATORY SERVICES	48,320.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,327.00	0.00
RECOVERY ROOM	655.00	0.00
LABORATORY PATHOLOGIC	160.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	850.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	236.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,028.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,050.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,540.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,706.00	518.00
OTHER LAB SERVICES	110.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	6,715.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,409.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	436,969.38	7,563.96
TOTAL ACCOMODATIONS	133,810.00	4,090.00
TOTAL CHARGES	570,779.38	11,653.96

ZERO PAID INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,129,099.66	ADJUSTMENTS	16,158.59
COVERED CHARGES	1,067,031.26	CONTRACTUAL ALLOW	478,739.71
NON-COVERED CHARGES	62,068.40	TOTAL MEDICAID LIAB	588,291.55
		LESS: COB	3,201.11
		LESS: COPAYMENT	1,908.00
		REIMBURSEMENT	583,182.44
		ALL OTHER	544,408.36
		FEE SCHEDULE-LAB	36,141.65
		INJECTABLE DRUGS	2,632.43

TOTAL NUMBER OF CLAIMS 2,542

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,720.60	0.00
MED/SURG SUPPLY	53,126.80	1,234.00
LABORATORY-GENERAL	286.00	2,606.00
RADIOLOGY-DIAGNOSTIC	107,465.00	2,391.00
CT SCAN	63,855.00	12,232.00
PHYSICAL THERAPY	30,966.00	2,232.00
EKG/ECG	8,768.00	392.00
IV THERAPY	22,370.00	1,500.00
OPERATING ROOM	174,205.00	2,550.00
LABOR/DELIVERY ROOM	900.00	0.00
RESPIRATORY SERVICES	23,100.00	160.00
ANESTHESIA	725.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	179,033.00	8,030.00
RECOVERY ROOM	16,506.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,297.00	0.00
SPEECH PATHOLOGY	13,775.00	630.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,540.00	650.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	29,835.00	287.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,610.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,390.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,494.00	99.00
OTHER LAB SERVICES	8,148.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	164,265.82	23,060.40
MRI SERVICES	38,975.00	1,400.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,285.04	5.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,067,031.26	62,068.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,067,031.26	62,068.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,501.40	ADJUSTMENTS	0.00
COVERED CHARGES	10,988.40	CONTRACTUAL ALLOW	4,054.57
NON-COVERED CHARGES	513.00	TOTAL MEDICAID LIAB	6,933.83
		LESS: COB	6,924.83
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	419.61-
		FEE SCHEDULE-LAB	389.51
		INJECTABLE DRUGS	30.10

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	785.40	0.00
MED/SURG SUPPLY	654.00	0.00
LABORATORY-GENERAL	0.00	53.00
RADIOLOGY-DIAGNOSTIC	1,415.00	0.00
CT SCAN	956.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	294.00	0.00
IV THERAPY	125.00	250.00
OPERATING ROOM	1,150.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	100.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,040.00	0.00
RECOVERY ROOM	262.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	21.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,180.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	242.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,716.00	210.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	48.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,988.40	513.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,988.40	513.00

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	57,836.98	ADJUSTMENTS	0.00
COVERED CHARGES	55,135.98	CONTRACTUAL ALLOW	38,685.98
NON-COVERED CHARGES	2,701.00	TOTAL MEDICAID LIAB	16,450.00
		LESS: COB	50.75
		LESS: COPAYMENT	279.00
		REIMBURSEMENT	16,120.25

TOTAL NUMBER OF CLAIMS 329

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,818.64	0.00
MED/SURG SUPPLY	1,610.00	0.00
LABORATORY-GENERAL	10,330.00	705.00
RADIOLOGY-DIAGNOSTIC	3,865.00	315.00
CT SCAN	0.00	956.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	98.00	0.00
IV THERAPY	1,500.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	353.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,190.00	725.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,420.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	951.34	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	55,135.98	2,701.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,135.98	2,701.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,765.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,513.75	CONTRACTUAL ALLOW	562.41
NON-COVERED CHARGES	252.00	TOTAL MEDICAID LIAB	951.34
		LESS: COB	951.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.00	0.00
MED/SURG SUPPLY	85.00	0.00
LABORATORY-GENERAL	549.00	7.00
RADIOLOGY-DIAGNOSTIC	124.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	615.00	245.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,513.75	252.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,513.75	252.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,572.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,572.00	CONTRACTUAL ALLOW	2,204.92
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,367.08
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,364.08

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270.00	0.00
MED/SURG SUPPLY	1,466.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,574.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	262.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,572.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,572.00	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
120 GORDON ST	000002087A	56	SERVICE DATES 05/01/2005 THROUGH 04/30/2006
	TITLE XVIII NO: 111325		
WASHINGTON GA 30673-1602			

****** NO DATA ******

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	507,110.64	ADJUSTMENTS	0.00
COVERED CHARGES	504,599.64	CONTRACTUAL ALLOW	237,415.78
NON-COVERED CHARGES	2,511.00	TOTAL MEDICAID LIAB	267,183.86
		LESS: COB	3,310.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	263,872.90

TOTAL NUMBER OF ADMISSIONS 65

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	191	0	66,850.00	2,150.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	191	0	66,850.00	2,150.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	66	0	64,680.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	66	0	64,680.00	0.00
TOTAL ACCOMODATIONS	257	0	131,530.00	2,150.00

INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,868.64	0.00
MED/SURG SUPPLY	41,059.00	0.00
LABORATORY-GENERAL	57,159.00	24.00
RADIOLOGY-DIAGNOSTIC	8,462.00	0.00
CT SCAN	24,087.00	0.00
PHYSICAL THERAPY	1,088.00	0.00
EKG/ECG	8,168.00	0.00
IV THERAPY	4,750.00	0.00
OPERATING ROOM	1,320.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50,139.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,979.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	84.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	927.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	3,825.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,704.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,002.00	300.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,490.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,014.00	37.00
OTHER LAB SERVICES	920.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,424.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	373,069.64	361.00
TOTAL ACCOMODATIONS	131,530.00	2,150.00
TOTAL CHARGES	504,599.64	2,511.00

ZERO PAID INPATIENT PAID CLAIMS

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	722,608.81	ADJUSTMENTS	16,046.09
COVERED CHARGES	668,280.81	CONTRACTUAL ALLOW	307,356.42
NON-COVERED CHARGES	54,328.00	TOTAL MEDICAID LIAB	360,924.39
		LESS: COB	1,183.59
		LESS: COPAYMENT	1,869.00
		REIMBURSEMENT	357,871.80
		ALL OTHER	329,848.62
		FEE SCHEDULE-LAB	26,428.63
		INJECTABLE DRUGS	1,594.55

TOTAL NUMBER OF CLAIMS 1,430

OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,278.61	74.00
MED/SURG SUPPLY	34,865.20	5.00
LABORATORY-GENERAL	0.00	2,445.00
RADIOLOGY-DIAGNOSTIC	51,104.00	846.00
CT SCAN	53,528.00	14,379.00
PHYSICAL THERAPY	20,376.00	1,742.00
EKG/ECG	9,995.00	0.00
IV THERAPY	18,300.00	0.00
OPERATING ROOM	91,448.00	2,550.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,640.00	0.00
ANESTHESIA	900.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	104,278.00	4,675.00
RECOVERY ROOM	8,122.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,815.00	0.00
SPEECH PATHOLOGY	6,620.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	974.00	805.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,822.00	996.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,929.00	900.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,620.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,945.00	0.00
OTHER LAB SERVICES	7,563.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	129,688.00	24,899.00
MRI SERVICES	22,900.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,570.00	12.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	668,280.81	54,328.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	668,280.81	54,328.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	3,551.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,800.25	CONTRACTUAL ALLOW	821.87
NON-COVERED CHARGES	751.00	TOTAL MEDICAID LIAB	1,978.38
		LESS: COB	1,966.38
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	150.09-
		FEE SCHEDULE-LAB	148.23
		INJECTABLE DRUGS	1.86

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245.25	88.00
MED/SURG SUPPLY	177.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	505.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	353.00	0.00
IV THERAPY	250.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	645.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	130.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	339.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	713.00	28.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,800.25	751.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,800.25	751.00

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	44,757.52	ADJUSTMENTS	50.00
COVERED CHARGES	42,441.52	CONTRACTUAL ALLOW	31,291.52
NON-COVERED CHARGES	2,316.00	TOTAL MEDICAID LIAB	11,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	240.00
		REIMBURSEMENT	10,910.00

TOTAL NUMBER OF CLAIMS 223

OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,064.52	0.00
MED/SURG SUPPLY	1,940.00	0.00
LABORATORY-GENERAL	10,307.00	583.00
RADIOLOGY-DIAGNOSTIC	2,032.00	167.00
CT SCAN	0.00	956.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	294.00	0.00
IV THERAPY	1,250.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	948.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,510.00	610.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	244.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	286.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	566.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,441.52	2,316.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,441.52	2,316.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
TITLE XVIII NO: 111325

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	22,351.50	ADJUSTMENTS	0.00
COVERED CHARGES	22,351.50	CONTRACTUAL ALLOW	8,883.18
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	13,468.32
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	13,456.32

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP
120 GORDON ST
WASHINGTON GA 30673-1602

PROVIDER NUMBER 000002087A
NUMBER OF BEDS 56
PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007
TITLE XVIII NO: 111325

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,061.50	0.00
MED/SURG SUPPLY	5,329.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	105.00	0.00
IV THERAPY	250.00	0.00
OPERATING ROOM	14,296.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,310.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22,351.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,351.50	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEM HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
120 GORDON ST	000002087A	56	SERVICE DATES 05/01/2006 THROUGH 04/30/2007
	TITLE XVIII NO: 111325		
WASHINGTON GA 30673-1602			

****** NO DATA ******

*** END OF REPORT ***