GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,090,280.49	ADJUSTMENTS	176,888.64
COVERED CHARGES	4,083,749.64	CONTRACTUAL ALLOW	2,390,858.86
NON-COVERD CHARGES	6,530.85	TOTAL MEDICAID LIAB	1,692,890.78
		LESS: COB	5,495.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,687,394.99

TOTAL NUMBER OF ADMISSIONS 288

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	666	0	340,293.00	0.00
ROUTINE NURSERY	132	0	60,852.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	798	4	401,145.00	0.00
SPECIAL CARE SERVICES				
CCU	96	0	105,216.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	96	0	105,216.00	0.00
TOTAL ACCOMODATIONS	894	4	506,361.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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126 US HWY 280 W
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	818,771.23	0.00
MED/SURG SUPPLY	688,658.49	782.54
LABORATORY-GENERAL	554,666.13	0.00
RADIOLOGY-DIAGNOSTIC	74,510.89	0.00
CT SCAN	138,387.33	0.00
PHYSICAL THERAPY	31,071.23	0.00
EKG/ECG	21,492.61	0.00
IV THERAPY	126,364.34	0.00
OPERATING ROOM	318,404.00	0.00
LABOR/DELIVERY ROOM	43,244.15	0.00
RESPIRATORY SERVICES	162,244.10	0.00
ANESTHESIA	66,185.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	87,663.71	0.00
RECOVERY ROOM	39,315.72	0.00
LABORATORY PATHOLOGIC	16,822.84	221.07
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,090.54	0.00
SPEECH PATHOLOGY	2,150.56	0.00
RENAL DIALYSIS	0.00	751.07
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,411.79
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	26,897.19	0.00
BLOOD	3,342.00	0.00
BLOOD STORAGE & PRO.	46,497.67	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,835.28	331.38
AUDIOLOGY	4,197.60	0.00
CARDIOLOGY	51,447.48	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,413.22	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	42,706.51	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,930.11	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	8,991.73	331.49
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	28,451.54	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	153,634.64	1,701.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,577,388.64	6,530.85
TOTAL ACCOMODATIONS	506,361.00	0.00
TOTAL CHARGES	4,083,749.64	6,530.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,295,370.39	ADJUSTMENTS	245,290.72
COVERED CHARGES	4,694,824.35	CONTRACTUAL ALLOW	3,230,768.67
NON-COVERD CHARGES	600,546.04	TOTAL MEDICAID LIAB	1,464,055.68
		LESS: COB	415.79
		LESS: COPAYMENT	6,088.98
		REIMBURSEMENT	1,457,550.91
		ALL OTHER	1,212,415.17
		FEE SCHEDULE-LAB	156,394.13
		INJECTABLE DRUGS	88,741.61

TOTAL NUMBER OF CLAIMS 4,304

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,812.28	1,164.32
MED/SURG SUPPLY	329,231.75	3,793.44
LABORATORY-GENERAL	0.00	253.96
RADIOLOGY-DIAGNOSTIC	279,446.43	10,643.89
CT SCAN	385,166.25	85,386.59
PHYSICAL THERAPY	37,877.27	18,676.08
EKG/ECG	59,567.02	4,358.22
IV THERAPY	357,328.53	35,757.81
OPERATING ROOM	432,173.90	51,522.50
LABOR/DELIVERY ROOM	4,108.30	0.00
RESPIRATORY SERVICES	17,221.80	6,823.16
ANESTHESIA	84,101.22	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	512,767.48	1,715.40
RECOVERY ROOM	76,310.76	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	37,148.96	0.00
OCCUPATIONAL THERAPY	0.00	757.09
SPEECH PATHOLOGY	716.92	2,971.22
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	139,182.97	24,442.72
PSYCHIATRIC SERVICES	209.11	0.00
LITHOTRIPSY	3,453.88	0.00
OTHER IMAGING SERVICE	146,673.71	8,261.95
BLOOD	40.00	334.20
BLOOD STORAGE & PRO.	13,974.97	2,763.06
ONCOLOGY	219.13	0.00
NUCLEAR MEDICINE	43,850.58	13,953.67
AUDIOLOGY	0.00	0.00
CARDIOLOGY	68,399.12	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,826.44	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	41,433.78	3,224.32

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	36,500.15	743.33
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	116.40
OTHER THERAPEUTIC SVC	3,598.60	41,718.59
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	712,076.33	145,031.00
MRI SERVICES	178,402.00	17,097.54
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,384.22
INJECTABLE DRUGS	351,004.71	113,731.69
HOME HEALTH SERVICES	0.00	40.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	282.97

TOTAL ANCILLARY	4,694,824.35	599,949.34
TOTAL ACCOMODATIONS	0.00	596.70
TOTAL CHARGES	4,694,824.35	600,546.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
6450	4010279019804	08/05/10 - 08/05/10	10/18/10	0.00	282.97	0.00	0.00	0.00
TOTAL				0.00	282.97	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,431.53	ADJUSTMENTS	0.00
COVERED CHARGES	21,076.49	CONTRACTUAL ALLOW	8,040.87
NON-COVERD CHARGES	4,355.04	TOTAL MEDICAID LIAB	13,035.62
		LESS: COB	13,023.62
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,069.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,015.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,249.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,532.39	240.88
EKG/ECG	0.00	0.00	MRI SERVICES	2,105.67	2,246.53
IV THERAPY	6,344.32	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,342.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	575.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,554.08	209.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	548.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39.73	285.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	153.64	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	659.32	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,933.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,076.49	4,231.76
TOTAL ACCOMODATIONS	0.00	123.28
TOTAL CHARGES	21,076.49	4,355.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	425,260.26	ADJUSTMENTS	4,388.82
COVERED CHARGES	406,622.59	CONTRACTUAL ALLOW	367,239.23
NON-COVERD CHARGES	18,637.67	TOTAL MEDICAID LIAB	39,383.36
		LESS: COB	0.00
		LESS: COPAYMENT	1,575.02
		REIMBURSEMENT	37,808.34

TOTAL NUMBER OF CLAIMS 710

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,352.38	11.02
MED/SURG SUPPLY	17,053.99	656.81
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,907.45	0.00
CT SCAN	16,548.42	2,218.71
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,657.70	0.00
IV THERAPY	22,569.91	627.33
OPERATING ROOM	0.00	40.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,574.33	218.41
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	202,959.94	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	3,792.98	468.21
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,627.29	1,580.14
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,444.18	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	743.33	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	711.61	5,783.52
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	47,514.93	6,568.96
MRI SERVICES	2,346.51	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,817.64	464.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	406,622.59	18,637.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	406,622.59	18,637.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,418,187.21	ADJUSTMENTS	52,853.10
COVERED CHARGES	1,314,565.31	CONTRACTUAL ALLOW	1,004,840.86
NON-COVERD CHARGES	103,621.90	TOTAL MEDICAID LIAB	309,724.45
		LESS: COB	60.00
		LESS: COPAYMENT	462.00
		REIMBURSEMENT	309,202.45

TOTAL NUMBER OF CLAIMS 59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
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PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,309.25	73.28
MED/SURG SUPPLY	91,740.59	246.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,770.20	351.25
CT SCAN	18,620.77	0.00
PHYSICAL THERAPY	0.00	737.59
EKG/ECG	1,711.98	166.72
IV THERAPY	136,770.32	9,200.84
OPERATING ROOM	77,980.00	6,684.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,678.46	2,752.95
ANESTHESIA	14,057.80	575.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,179.38	418.22
RECOVERY ROOM	8,145.22	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	54,233.75	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	8,882.20	419.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,500.24	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,429.68	1,381.53
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,866.36	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,046.24	505.44

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,119.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	209.11
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,273.51	6,845.49
MRI SERVICES	10,732.96	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	784,516.80	73,054.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,314,565.31	103,621.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,314,565.31	103,621.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,603,838.77	ADJUSTMENTS	11,547.57
COVERED CHARGES	2,559,075.50	CONTRACTUAL ALLOW	1,509,016.89
NON-COVERD CHARGES	44,763.27	TOTAL MEDICAID LIAB	1,050,058.61
		LESS: COB	11,675.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,038,382.65

TOTAL NUMBER OF ADMISSIONS 248

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	687	0	322,638.00	38,683.00
ROUTINE NURSERY	109	0	24,942.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	796	0	347,580.00	38,683.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	66	0	68,778.00	0.00
NICU	2	0	1,258.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	68	0	70,036.00	0.00
TOTAL ACCOMODATIONS	864	0	417,616.00	38,683.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162,899.88	0.00	OTHER LAB	15,558.00	0.00
MED/SURG SUPPLY	168,407.65	60.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	387,726.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,541.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,105.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,658.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	20,390.00	0.00	MRI SERVICES	33,728.00	0.00
IV THERAPY	117,567.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	103,672.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	146,336.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	198,039.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,216.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,372.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,015.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,146.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	448,394.97	536.79
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	555.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,283.00	2,935.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,375.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,918.00	2,548.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,489.00	0.00			
AUDIOLOGY	3,082.00	0.00			
CARDIOLOGY	23,620.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,215.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,151.00	0.00			

TOTAL ANCILLARY	2,141,459.50	6,080.27
TOTAL ACCOMODATIONS	417,616.00	38,683.00
TOTAL CHARGES	2,559,075.50	44,763.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,871,179.33	ADJUSTMENTS	23,034.15
COVERED CHARGES	2,454,660.74	CONTRACTUAL ALLOW	1,955,857.48
NON-COVERD CHARGES	416,518.59	TOTAL MEDICAID LIAB	498,803.26
		LESS: COB	1,450.16
		LESS: COPAYMENT	2,770.20
		REIMBURSEMENT	494,582.90
		ALL OTHER	367,944.06
		FEE SCHEDULE-LAB	62,931.10
		INJECTABLE DRUGS	63,707.74

TOTAL NUMBER OF CLAIMS 2,488

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,615.03	1,014.35
MED/SURG SUPPLY	67,968.96	2,658.62
LABORATORY-GENERAL	0.00	678.00
RADIOLOGY-DIAGNOSTIC	115,973.00	567.00
CT SCAN	199,995.00	30,491.00
PHYSICAL THERAPY	9,575.00	1,584.00
EKG/ECG	28,136.00	450.00
IV THERAPY	226,709.00	4,519.00
OPERATING ROOM	80,233.00	28,151.00
LABOR/DELIVERY ROOM	1,972.00	0.00
RESPIRATORY SERVICES	20,182.00	8,803.00
ANESTHESIA	41,387.00	0.00
GI SERVICES	16,284.00	2,124.00
EMERGENCY ROOM	255,633.19	1,303.81
RECOVERY ROOM	35,786.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	16,463.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,755.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	46,440.00	1,265.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,743.00	3,822.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,579.00	5,342.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,119.00	148.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,745.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	61,565.00	4,446.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,129.00	412.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	230.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	561,885.00	129,731.00
MRI SERVICES	78,342.00	5,101.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	125.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	409,321.56	183,677.81
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,454,660.74	416,518.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,454,660.74	416,518.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,659.57	ADJUSTMENTS	0.00
COVERED CHARGES	31,344.55	CONTRACTUAL ALLOW	15,457.89
NON-COVERD CHARGES	14,315.02	TOTAL MEDICAID LIAB	15,886.66
		LESS: COB	15,865.66
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,243.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,941.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,610.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,319.00	2,445.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,398.00	952.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,146.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	6,755.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	219.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,002.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,693.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,169.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,700.50	874.02
RADIOLOGY THERAPEUTIC	664.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	274.00	2,671.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,022.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	618.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,943.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,344.55	14,315.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,344.55	14,315.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,326.82	ADJUSTMENTS	641.28
COVERED CHARGES	82,072.00	CONTRACTUAL ALLOW	75,527.02
NON-COVERD CHARGES	4,254.82	TOTAL MEDICAID LIAB	6,544.98
		LESS: COB	0.00
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	6,316.98

TOTAL NUMBER OF CLAIMS 117

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	675.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	703.57	117.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,294.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,539.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,045.00	3,536.80
EKG/ECG	734.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,551.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	441.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,366.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	614.82	600.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,108.00	0.00			

TOTAL ANCILLARY	82,072.00	4,254.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,072.00	4,254.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,935.88	ADJUSTMENTS	0.00
COVERED CHARGES	20,949.58	CONTRACTUAL ALLOW	15,949.67
NON-COVERD CHARGES	986.30	TOTAL MEDICAID LIAB	4,999.91
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,999.91

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	974.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,236.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	485.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	699.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,569.00	174.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,684.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,627.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	647.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	621.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	965.99	782.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	440.00	0.00			

TOTAL ANCILLARY	20,949.58	986.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,949.58	986.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
PO BOX 2070
BAXLEY,GA 31515-2070

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,952,580.54	ADJUSTMENTS	951,381.49
COVERED CHARGES	23,635,001.26	CONTRACTUAL ALLOW	15,165,988.03
NON-COVERD CHARGES	317,579.28	TOTAL MEDICAID LIAB	8,469,013.23
		LESS: COB	23,838.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,445,174.50

TOTAL NUMBER OF ADMISSIONS 1,051

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,519	4	3,763,061.00	78,456.00
ROUTINE NURSERY	96	0	49,145.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	15	0.00	0.00
TOTAL ROUTINE	5,615	19	3,812,206.00	78,456.00
SPECIAL CARE SERVICES				
CCU	79	0	84,145.00	0.00
ICU	807	0	948,311.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	24	0	10,176.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	136	0.00	99,344.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	910	136	1,042,632.00	99,344.00
TOTAL ACCOMODATIONS	6,525	155	4,854,838.00	177,800.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,355,406.47	254.00
MED/SURG SUPPLY	3,189,260.00	12,073.00
LABORATORY-GENERAL	3,368,873.79	159.28
RADIOLOGY-DIAGNOSTIC	546,740.00	0.00
CT SCAN	847,175.00	10,676.00
PHYSICAL THERAPY	225,702.00	0.00
EKG/ECG	65,719.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,581,523.00	1,812.00
LABOR/DELIVERY ROOM	84,663.00	0.00
RESPIRATORY SERVICES	622,956.00	2,485.00
ANESTHESIA	113,112.00	0.00
GI SERVICES	84,116.00	0.00
EMERGENCY ROOM	677,681.00	6,608.00
RECOVERY ROOM	138,484.00	0.00
LABORATORY PATHOLOGIC	98,341.00	0.00
RADIOLOGY THERAPEUTIC	250,008.00	1,503.00
OCCUPATIONAL THERAPY	84,093.00	0.00
SPEECH PATHOLOGY	35,516.00	0.00
RENAL DIALYSIS	148,013.00	47,731.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	4,643.00
PSYCHIATRIC SERVICES	1,534.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	58,475.00	21,910.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	375,276.00	14,210.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,284.00	0.00
AUDIOLOGY	4,574.00	0.00
CARDIOLOGY	464,623.00	451.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,180.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	48,654.00	128.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	49,183.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	15,136.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	200,998.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,780,163.26	139,779.28
TOTAL ACCOMODATIONS	4,854,838.00	177,800.00
TOTAL CHARGES	23,635,001.26	317,579.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,064.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,064.00	CONTRACTUAL ALLOW	336.43
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,727.57
		LESS: COB	1,727.57
		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	0	0	0.00	0.00
ROUTINE NURSERY	2	0	882.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	882.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	882.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	631.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	331.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	114.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14.00	0.00			

TOTAL ANCILLARY	1,182.00	0.00
TOTAL ACCOMODATIONS	882.00	0.00
TOTAL CHARGES	2,064.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,069,195.77	ADJUSTMENTS	433,856.38
COVERED CHARGES	12,636,611.19	CONTRACTUAL ALLOW	9,607,487.41
NON-COVERD CHARGES	1,432,584.58	TOTAL MEDICAID LIAB	3,029,123.78
		LESS: COB	225.35
		LESS: COPAYMENT	16,838.39
		REIMBURSEMENT	3,012,060.04
		ALL OTHER	2,273,844.89
		FEE SCHEDULE-LAB	272,239.72
		INJECTABLE DRUGS	465,975.43

TOTAL NUMBER OF CLAIMS 8,581

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	369,576.11	23,475.25
MED/SURG SUPPLY	801,106.00	11,889.00
LABORATORY-GENERAL	0.00	68.00
RADIOLOGY-DIAGNOSTIC	425,186.00	26,976.00
CT SCAN	1,100,615.00	103,316.00
PHYSICAL THERAPY	18,818.00	6,468.00
EKG/ECG	61,820.00	2,613.00
IV THERAPY	142,829.00	6,736.00
OPERATING ROOM	1,186,104.07	194,888.13
LABOR/DELIVERY ROOM	37,820.00	0.00
RESPIRATORY SERVICES	30,554.00	58,759.00
ANESTHESIA	88,800.00	14,192.00
GI SERVICES	188,836.29	27,587.71
EMERGENCY ROOM	795,988.00	11,880.00
RECOVERY ROOM	170,190.00	0.00
LABORATORY PATHOLOGIC	0.00	232.00
RADIOLOGY THERAPEUTIC	1,198,119.00	65,662.00
OCCUPATIONAL THERAPY	6,873.00	3,445.00
SPEECH PATHOLOGY	3,604.00	4,065.00
RENAL DIALYSIS	0.00	445.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	238,367.00	49,542.00
PSYCHIATRIC SERVICES	67,362.00	0.00
LITHOTRIPSY	9,402.00	0.00
OTHER IMAGING SERVICE	310,090.00	24,030.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	40,484.00	33,990.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	176,909.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	213,187.00	55,310.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	107,275.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	144,280.00	28,869.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	62,523.00	3,455.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	208.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,753,090.15	331,426.92
MRI SERVICES	463,670.00	14,169.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,423,133.57	328,887.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,636,611.19	1,432,584.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,636,611.19	1,432,584.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,861.00	ADJUSTMENTS	0.00
COVERED CHARGES	29,766.00	CONTRACTUAL ALLOW	19,808.76
NON-COVERD CHARGES	31,095.00	TOTAL MEDICAID LIAB	9,957.24
		LESS: COB	9,813.02
		LESS: COPAYMENT	144.22
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,094.00	0.00
MED/SURG SUPPLY	783.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	887.00	0.00
CT SCAN	3,517.00	1,219.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,160.00	0.00
IV THERAPY	131.00	0.00
OPERATING ROOM	2,493.00	230.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	14,186.00
ANESTHESIA	248.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,013.00	0.00
RECOVERY ROOM	626.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	948.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,153.00	3,428.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	945.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	971.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,851.00	898.00
MRI SERVICES	4,734.00	2,446.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	212.00	8,688.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	29,766.00	31,095.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,766.00	31,095.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	269,596.32	ADJUSTMENTS	1,845.97
COVERED CHARGES	250,845.22	CONTRACTUAL ALLOW	227,221.27
NON-COVERD CHARGES	18,751.10	TOTAL MEDICAID LIAB	23,623.95
		LESS: COB	46.72
		LESS: COPAYMENT	855.04
		REIMBURSEMENT	22,722.19

TOTAL NUMBER OF CLAIMS 426

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,705.00	1,053.00
MED/SURG SUPPLY	6,693.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,297.00	0.00
CT SCAN	16,846.00	4,258.00
PHYSICAL THERAPY	0.00	194.00
EKG/ECG	1,231.00	0.00
IV THERAPY	3,814.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,290.00	0.00
RESPIRATORY SERVICES	1,505.00	932.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	130,172.00	1,547.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,373.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	64.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,636.00	298.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,929.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	834.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60,870.50	6,696.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,649.72	3,709.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	250,845.22	18,751.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	250,845.22	18,751.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,286,271.93	ADJUSTMENTS	147,750.58
COVERED CHARGES	3,013,863.25	CONTRACTUAL ALLOW	2,399,809.07
NON-COVERD CHARGES	272,408.68	TOTAL MEDICAID LIAB	614,054.18
		LESS: COB	0.00
		LESS: COPAYMENT	527.49
		REIMBURSEMENT	613,526.69

TOTAL NUMBER OF CLAIMS 120

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,973.00	1,713.00	OTHER LAB	514.00	0.00
MED/SURG SUPPLY	630,478.00	32.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,286.00	30,057.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	257.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,150.00	FEE SCHEDULE LAB	33,199.00	3,557.00
EKG/ECG	3,007.00	0.00	MRI SERVICES	0.00	8,380.00
IV THERAPY	6,033.00	131.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290,050.37	133,439.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	593.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,134.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,476,870.88	76,806.05
RADIOLOGY THERAPEUTIC	344,009.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,498.00	6,156.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	609.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,122.00	484.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,637.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	58,983.00	6,585.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94.00	3,661.00			

TOTAL ANCILLARY	3,013,863.25	272,408.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,013,863.25	272,408.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	53,466,480.22	ADJUSTMENTS	1,235,930.96
COVERED CHARGES	52,349,545.60	CONTRACTUAL ALLOW	37,069,919.89
NON-COVERD CHARGES	1,116,934.62	TOTAL MEDICAID LIAB	15,279,625.71
		LESS: COB	97,593.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,182,032.61

TOTAL NUMBER OF ADMISSIONS 1,992

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,431	70	4,385,472.60	583,234.52
ROUTINE NURSERY	1,082	72	930,628.00	305,446.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	3.00	15.00
TOTAL ROUTINE	7,513	145	5,316,103.60	888,695.52
SPECIAL CARE SERVICES				
CCU	136	0	264,778.00	0.00
ICU	775	0	1,511,251.00	0.00
NICU	226	0	587,600.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,137	0	2,363,629.00	0.00
TOTAL ACCOMODATIONS	8,650	145	7,679,732.60	888,695.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,907,138.10	4,465.97
MED/SURG SUPPLY	5,401,172.34	18,478.26
LABORATORY-GENERAL	7,378,157.52	2,994.73
RADIOLOGY-DIAGNOSTIC	1,057,087.13	0.00
CT SCAN	2,152,452.00	19,600.00
PHYSICAL THERAPY	150,087.57	348.00
EKG/ECG	1,322,134.82	0.00
IV THERAPY	16,421.32	0.00
OPERATING ROOM	4,810,165.63	16,663.00
LABOR/DELIVERY ROOM	2,415,061.50	5,328.50
RESPIRATORY SERVICES	2,226,899.87	7,049.54
ANESTHESIA	203,393.84	0.00
GI SERVICES	368,536.75	0.00
EMERGENCY ROOM	1,122,534.37	78.40
RECOVERY ROOM	512,115.84	709.92
LABORATORY PATHOLOGIC	429,431.05	542.57
RADIOLOGY THERAPEUTIC	218,840.00	0.00
OCCUPATIONAL THERAPY	93,597.13	0.00
SPEECH PATHOLOGY	73,694.17	660.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	105.40	5,895.41
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	311,698.84	16,446.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	647,471.03	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	188,728.58	0.00
AUDIOLOGY	18,948.10	0.00
CARDIOLOGY	1,433,594.79	750.41
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	104,770.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	437,106.90	1,940.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	307,187.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	32,054.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	678,766.00	0.00
PROFESSIONAL FEES	0.00	34.07
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,682,514.66	84,850.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	9,184.00
NO CC/INVALID REV CODE	0.00	166.00

TOTAL ANCILLARY	44,669,813.00	228,239.10
TOTAL ACCOMODATIONS	7,679,732.60	888,695.52
TOTAL CHARGES	52,349,545.60	1,116,934.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
285	2211297008160	03/06/11 - 03/23/11	10/31/11	0.00	166.00	0.00	0.00	0.00
TOTAL				0.00	166.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,722,272.76	ADJUSTMENTS	0.00
COVERED CHARGES	1,634,117.85	CONTRACTUAL ALLOW	711,655.62
NON-COVERD CHARGES	88,154.91	TOTAL MEDICAID LIAB	922,462.23
		LESS: COB	922,462.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	63	0	35,056.64	10,169.00
ROUTINE NURSERY	98	0	133,977.00	42,231.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	161	0	169,033.64	52,400.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	13,643.00	0.00
NICU	185	0	481,000.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	192	0	494,643.00	0.00
TOTAL ACCOMODATIONS	353	0	663,676.64	52,400.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220,137.17	3,121.69
MED/SURG SUPPLY	153,566.02	970.11
LABORATORY-GENERAL	200,852.19	6,162.82
RADIOLOGY-DIAGNOSTIC	31,603.00	472.00
CT SCAN	30,705.00	6,757.00
PHYSICAL THERAPY	1,030.21	0.00
EKG/ECG	1,338.40	267.68
IV THERAPY	0.00	0.00
OPERATING ROOM	61,413.14	0.00
LABOR/DELIVERY ROOM	30,479.46	0.00
RESPIRATORY SERVICES	69,632.27	0.00
ANESTHESIA	3,297.69	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,334.69	1,255.00
RECOVERY ROOM	3,619.11	0.00
LABORATORY PATHOLOGIC	3,041.67	0.00
RADIOLOGY THERAPEUTIC	0.00	10,320.00
OCCUPATIONAL THERAPY	11,590.29	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	156.58
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,980.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,796.60	1,250.26
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,030.27	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,365.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,720.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,895.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80,013.84	5,021.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	970,441.21	35,754.91
TOTAL ACCOMODATIONS	663,676.64	52,400.00
TOTAL CHARGES	1,634,117.85	88,154.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,145,553.02	ADJUSTMENTS	1,422,330.04
COVERED CHARGES	26,166,493.99	CONTRACTUAL ALLOW	20,690,927.50
NON-COVERD CHARGES	2,979,059.03	TOTAL MEDICAID LIAB	5,475,566.49
		LESS: COB	18,082.38
		LESS: COPAYMENT	18,984.88
		REIMBURSEMENT	5,438,499.23
		ALL OTHER	4,563,266.42
		FEE SCHEDULE-LAB	690,815.83
		INJECTABLE DRUGS	184,416.98

TOTAL NUMBER OF CLAIMS 13,235

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	738,092.92	2,148.12
MED/SURG SUPPLY	1,068,489.39	109,876.48
LABORATORY-GENERAL	0.00	4,412.34
RADIOLOGY-DIAGNOSTIC	1,124,019.66	33,376.57
CT SCAN	3,068,584.00	183,050.00
PHYSICAL THERAPY	56,446.89	11,471.20
EKG/ECG	518,490.77	2,371.76
IV THERAPY	684,887.41	0.00
OPERATING ROOM	2,378,696.15	398,485.73
LABOR/DELIVERY ROOM	217,704.46	0.00
RESPIRATORY SERVICES	253,966.88	23,988.70
ANESTHESIA	131,787.51	966.62
GI SERVICES	349,529.30	37,392.18
EMERGENCY ROOM	3,890,883.67	11,667.34
RECOVERY ROOM	431,309.38	2,598.21
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	184,052.05	4,070.00
OCCUPATIONAL THERAPY	13,640.90	2,749.28
SPEECH PATHOLOGY	7,077.31	6,241.24
RENAL DIALYSIS	0.00	2,419.54
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	103,274.94	997.38
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	15,795.00	0.00
OTHER IMAGING SERVICE	668,177.21	35,722.55
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	106,203.12	25,233.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,275,923.08	57,707.00
AUDIOLOGY	734.44	0.00
CARDIOLOGY	764,986.83	268,154.54
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	437,186.26	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	583,884.17	13,480.88

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	450,147.40	14,482.78
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	325.35	321.87
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,531,067.05	1,199,473.71
MRI SERVICES	960,900.00	37,935.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,150,230.49	472,931.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	13,776.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	26,166,493.99	2,977,501.03
TOTAL ACCOMODATIONS	0.00	1,558.00
TOTAL CHARGES	26,166,493.99	2,979,059.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	468,024.36	ADJUSTMENTS	0.00
COVERED CHARGES	363,176.07	CONTRACTUAL ALLOW	193,277.22
NON-COVERD CHARGES	104,848.29	TOTAL MEDICAID LIAB	169,898.85
		LESS: COB	169,718.45
		LESS: COPAYMENT	180.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 190

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,548.04	46.70
MED/SURG SUPPLY	11,118.00	1,038.71
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,921.06	1,361.67
CT SCAN	55,649.00	35,580.00
PHYSICAL THERAPY	0.00	1,297.26
EKG/ECG	3,615.37	267.68
IV THERAPY	8,215.95	0.00
OPERATING ROOM	37,857.19	28,207.13
LABOR/DELIVERY ROOM	12,755.04	0.00
RESPIRATORY SERVICES	2,711.49	1,067.01
ANESTHESIA	4,208.67	0.00
GI SERVICES	2,297.56	0.00
EMERGENCY ROOM	68,510.14	1,411.80
RECOVERY ROOM	11,901.46	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,778.01	66.79
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,382.27	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,250.26	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,145.74	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,232.96	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,898.69	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,279.17	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	73,227.74	15,650.84
MRI SERVICES	6,932.00	8,685.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,740.26	10,167.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	363,176.07	104,848.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	363,176.07	104,848.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	881,203.05	ADJUSTMENTS	2,099.56
COVERED CHARGES	822,283.82	CONTRACTUAL ALLOW	789,078.05
NON-COVERD CHARGES	58,919.23	TOTAL MEDICAID LIAB	33,205.77
		LESS: COB	0.00
		LESS: COPAYMENT	1,182.08
		REIMBURSEMENT	32,023.69

TOTAL NUMBER OF CLAIMS 594

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,245.99	5.32
MED/SURG SUPPLY	9,537.49	544.89
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,013.00	0.00
CT SCAN	49,933.00	3,517.00
PHYSICAL THERAPY	0.00	239.25
EKG/ECG	7,630.57	0.00
IV THERAPY	18,565.96	0.00
OPERATING ROOM	2,233.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,553.53	1,169.67
ANESTHESIA	268.31	0.00
GI SERVICES	325.00	0.00
EMERGENCY ROOM	436,742.78	169.79
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	11,045.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	180.07	170.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,385.00	2,880.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	625.13	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,750.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,577.51	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,115.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,512.79	3,057.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	171,202.08	34,300.97
MRI SERVICES	10,781.00	4,380.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,060.76	8,485.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	822,283.82	58,919.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	822,283.82	58,919.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,398.08	ADJUSTMENTS	0.00
COVERED CHARGES	18,534.64	CONTRACTUAL ALLOW	8,104.07
NON-COVERD CHARGES	1,863.44	TOTAL MEDICAID LIAB	10,430.57
		LESS: COB	10,421.57
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	589.75	0.00
MED/SURG SUPPLY	85.59	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,549.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	582.31	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	152.43	304.86
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,397.10	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 SERVICE	405.00	310.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,522.62	735.26
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	250.84	513.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,534.64	1,863.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,534.64	1,863.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,352,016.32	ADJUSTMENTS	303,139.34
COVERED CHARGES	3,058,824.67	CONTRACTUAL ALLOW	2,553,542.10
NON-COVERD CHARGES	293,191.65	TOTAL MEDICAID LIAB	505,282.57
		LESS: COB	0.00
		LESS: COPAYMENT	882.00
		REIMBURSEMENT	504,400.57

TOTAL NUMBER OF CLAIMS 96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,530.52	0.00
MED/SURG SUPPLY	1,003,607.45	38,400.32
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,860.12	4,766.00
CT SCAN	122,426.00	4,604.00
PHYSICAL THERAPY	0.00	396.00
EKG/ECG	52,021.18	535.36
IV THERAPY	10,366.72	0.00
OPERATING ROOM	507,206.07	38,060.29
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,473.62	0.00
ANESTHESIA	20,543.23	0.00
GI SERVICES	28,343.03	2.00
EMERGENCY ROOM	15,602.00	0.00
RECOVERY ROOM	42,530.24	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	282,676.25	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	431.20
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,665.79	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,735.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41,411.44	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,595.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	271,090.99	57,108.83
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,705.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,354.45	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	11,466.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	146,319.75	90,795.25
MRI SERVICES	5,193.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	334,567.38	46,626.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,058,824.67	293,191.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,058,824.67	293,191.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,673,357.77	ADJUSTMENTS	22,280.26
COVERED CHARGES	1,612,031.37	CONTRACTUAL ALLOW	1,085,653.98
NON-COVERD CHARGES	61,326.40	TOTAL MEDICAID LIAB	526,377.39
		LESS: COB	15,387.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	510,989.62

TOTAL NUMBER OF ADMISSIONS 100

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	335	25	196,980.00	20,460.00
ROUTINE NURSERY	12	0	6,506.00	357.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	347	25	203,486.00	20,817.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	58	0	64,260.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	64,260.00	0.00
TOTAL ACCOMODATIONS	405	25	267,746.00	20,817.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,806.90	0.00
MED/SURG SUPPLY	258,946.38	0.00
LABORATORY-GENERAL	267,668.40	0.00
RADIOLOGY-DIAGNOSTIC	34,481.70	0.00
CT SCAN	54,130.50	6,265.00
PHYSICAL THERAPY	12,710.60	0.00
EKG/ECG	18,814.00	0.00
IV THERAPY	3,956.30	30,887.00
OPERATING ROOM	125,128.20	0.00
LABOR/DELIVERY ROOM	2,567.30	0.00
RESPIRATORY SERVICES	67,126.36	0.00
ANESTHESIA	4,102.73	0.00
GI SERVICES	1,295.10	0.00
EMERGENCY ROOM	57,045.20	0.00
RECOVERY ROOM	7,686.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,946.30	0.00
SPEECH PATHOLOGY	2,626.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,535.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,452.00	3,357.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,316.00	0.00
AUDIOLOGY	64.00	0.00
CARDIOLOGY	11,141.90	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/OBSERV. RM	2,820.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,628.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,289.30	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,344,285.37	40,509.40
TOTAL ACCOMODATIONS	267,746.00	20,817.00
TOTAL CHARGES	1,612,031.37	61,326.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,672,855.40	ADJUSTMENTS	25,983.07
COVERED CHARGES	1,355,971.66	CONTRACTUAL ALLOW	991,319.71
NON-COVERD CHARGES	316,883.74	TOTAL MEDICAID LIAB	364,651.95
		LESS: COB	0.00
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	362,971.95
		ALL OTHER	324,091.78
		FEE SCHEDULE-LAB	38,880.17
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,515

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,378.30	2,334.20	OTHER LAB	3,729.70	0.00
MED/SURG SUPPLY	129,403.78	2,328.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,743.30	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,727.70	2,052.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	102,543.20	95,061.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,730.70	3,784.10	FEE SCHEDULE LAB	399,526.80	108,000.54
EKG/ECG	30,194.20	981.60	MRI SERVICES	46,758.80	0.00
IV THERAPY	5,556.00	24,193.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,515.80	45,204.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,929.60	341.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	57,708.30	11,705.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	246,902.78	4,239.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,856.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,148.30	5,580.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	681.50
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	38,285.50	3,404.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,184.00	3,644.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,199.30	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,012.90	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/OBSERV. RM	6,680.00	0.00			

TOTAL ANCILLARY	1,355,971.66	316,279.74
TOTAL ACCOMODATIONS	0.00	604.00
TOTAL CHARGES	1,355,971.66	316,883.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
6	4010211008603	07/11/10 - 07/11/10	08/09/10	0.00	57.50	0.00	0.00	0.00
6	4010211008603	07/11/10 - 07/11/10	08/09/10	0.00	74.20	0.00	0.00	0.00
6	4010211008603	07/11/10 - 07/11/10	08/09/10	0.00	136.50	0.00	0.00	0.00
6	4010211008603	07/11/10 - 07/11/10	08/09/10	0.00	103.50	0.00	0.00	0.00
6	4010211008603	07/11/10 - 07/11/10	08/09/10	0.00	83.00	0.00	0.00	0.00
24	4010225009342	07/06/10 - 07/06/10	08/23/10	0.00	226.80	0.00	0.00	0.00
TOTAL				0.00	681.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,698.70	ADJUSTMENTS	0.00
COVERED CHARGES	4,714.50	CONTRACTUAL ALLOW	1,793.10
NON-COVERD CHARGES	984.20	TOTAL MEDICAID LIAB	2,921.40
		LESS: COB	2,906.40
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	226.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,912.40	884.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	92.60	100.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	658.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	549.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,714.50	984.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,714.50	984.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	238,299.12	ADJUSTMENTS	723.00
COVERED CHARGES	205,514.32	CONTRACTUAL ALLOW	187,814.32
NON-COVERD CHARGES	32,784.80	TOTAL MEDICAID LIAB	17,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	603.00
		REIMBURSEMENT	17,097.00

TOTAL NUMBER OF CLAIMS 354

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,986.80	501.80
MED/SURG SUPPLY	2,484.42	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,316.80	5,424.30
CT SCAN	15,658.50	11,172.40
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,126.80	0.00
IV THERAPY	1,111.20	3,020.20
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	753.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	102,104.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	15.90
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,688.60	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,716.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,566.50	9,700.50
MRI SERVICES	0.00	2,949.70
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	205,514.32	32,784.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,514.32	32,784.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,927.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,524.10	CONTRACTUAL ALLOW	3,521.10
NON-COVERD CHARGES	402.90	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	198.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	341.70	FEE SCHEDULE LAB	1,661.70	15.90
EKG/ECG	163.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,418.60	45.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,524.10	402.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,524.10	402.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,358.00	ADJUSTMENTS	4,473.69
COVERED CHARGES	33,363.40	CONTRACTUAL ALLOW	24,410.02
NON-COVERD CHARGES	3,994.60	TOTAL MEDICAID LIAB	8,953.38
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	8,944.38

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	867.10	307.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,168.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	399.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,801.80	3,226.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	619.70	204.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	255.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,865.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	366.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	276.00	0.00			

TOTAL ANCILLARY	33,363.40	3,994.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,363.40	3,994.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,218,350.00	ADJUSTMENTS	460,171.60
COVERED CHARGES	6,125,527.54	CONTRACTUAL ALLOW	3,776,147.57
NON-COVERD CHARGES	92,822.46	TOTAL MEDICAID LIAB	2,349,379.97
		LESS: COB	46,108.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,303,271.95

TOTAL NUMBER OF ADMISSIONS 325

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	680	9	478,196.87	29,685.70
ROUTINE NURSERY	117	0	69,943.77	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	797	9	548,140.64	29,685.70
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	757	22	919,543.92	21,305.02
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	757	22	919,543.92	21,305.02
TOTAL ACCOMODATIONS	1,554	31	1,467,684.56	50,990.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,064,896.81	2,119.92
MED/SURG SUPPLY	553,101.46	3,063.68
LABORATORY-GENERAL	905,229.84	2,829.28
RADIOLOGY-DIAGNOSTIC	86,251.41	209.58
CT SCAN	250,987.73	9,011.96
PHYSICAL THERAPY	17,481.25	0.00
EKG/ECG	20,773.92	100.62
IV THERAPY	14,936.42	205.85
OPERATING ROOM	161,018.26	1,428.80
LABOR/DELIVERY ROOM	80,061.26	2,309.98
RESPIRATORY SERVICES	234,605.89	1,024.26
ANESTHESIA	0.00	0.00
GI SERVICES	38,557.02	0.00
EMERGENCY ROOM	146,320.08	1,473.36
RECOVERY ROOM	26,652.47	0.00
LABORATORY PATHOLOGIC	24,048.51	0.00
RADIOLOGY THERAPEUTIC	16,971.42	0.00
OCCUPATIONAL THERAPY	5,673.43	0.00
SPEECH PATHOLOGY	4,683.30	0.00
RENAL DIALYSIS	24,011.24	1,756.92
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,088.54	3,314.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	25,039.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	98,839.32	1,971.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	62,466.52	1,149.30
AUDIOLOGY	3,799.60	0.00
CARDIOLOGY	106,911.74	0.00
AMBULATORY SURGERY	542.31	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,954.95	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,891.19	1,812.36

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,978.51	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	34,262.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	621,806.63	1,530.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	6,519.50

TOTAL ANCILLARY	4,657,842.98	41,831.74
TOTAL ACCOMODATIONS	1,467,684.56	50,990.72
TOTAL CHARGES	6,125,527.54	92,822.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011063054526	01/03/11 - 01/07/11	03/07/11	0.00	3,259.75	0.00	0.00	0.00
615	2011291042343	04/06/11 - 04/09/11	10/24/11	0.00	3,259.75	0.00	0.00	0.00
TOTAL				0.00	6,519.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,755,501.87	ADJUSTMENTS	275,146.46
COVERED CHARGES	5,120,106.10	CONTRACTUAL ALLOW	3,702,449.68
NON-COVERD CHARGES	635,395.77	TOTAL MEDICAID LIAB	1,417,656.42
		LESS: COB	1,452.06
		LESS: COPAYMENT	6,514.57
		REIMBURSEMENT	1,409,689.79
		ALL OTHER	1,119,353.99
		FEE SCHEDULE-LAB	240,181.49
		INJECTABLE DRUGS	50,154.31

TOTAL NUMBER OF CLAIMS 5,004

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,091.81	11,872.97
MED/SURG SUPPLY	224,828.48	26,266.56
LABORATORY-GENERAL	0.00	174.84
RADIOLOGY-DIAGNOSTIC	231,846.54	2,730.34
CT SCAN	684,795.18	39,302.91
PHYSICAL THERAPY	4,172.20	3,346.78
EKG/ECG	52,754.78	1,956.40
IV THERAPY	128,183.64	271.97
OPERATING ROOM	206,645.55	21,151.08
LABOR/DELIVERY ROOM	2,309.98	0.00
RESPIRATORY SERVICES	65,172.22	2,093.27
ANESTHESIA	0.00	0.00
GI SERVICES	30,912.24	3,572.04
EMERGENCY ROOM	649,580.80	11,778.23
RECOVERY ROOM	38,993.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	221,220.99	8,509.98
OCCUPATIONAL THERAPY	2,942.80	1,572.51
SPEECH PATHOLOGY	0.00	4,867.55
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	27,706.98	1,147.38
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,548.17	0.00
OTHER IMAGING SERVICE	201,759.99	23,161.69
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,199.06	985.54
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	182,866.88	5,865.63
AUDIOLOGY	0.00	0.00
CARDIOLOGY	85,390.85	2,757.87
AMBULATORY SURGERY	1,853.36	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	45,259.73	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	172,070.22	9,410.19

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	34,065.59	1,005.29
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,374,133.47	309,140.12
MRI SERVICES	109,559.51	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	181,241.48	142,454.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,120,106.10	635,395.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,120,106.10	635,395.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,595.83	ADJUSTMENTS	0.00
COVERED CHARGES	12,732.62	CONTRACTUAL ALLOW	12,660.77
NON-COVERD CHARGES	863.21	TOTAL MEDICAID LIAB	71.85
		LESS: COB	59.85
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	257.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	621.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,754.99	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,687.84	474.40
EKG/ECG	100.62	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,402.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	943.58	164.76	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	336.00	224.05
RADIOLOGY THERAPEUTIC	60.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	478.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,732.62	863.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,732.62	863.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	271,102.76	ADJUSTMENTS	800.10
COVERED CHARGES	250,518.77	CONTRACTUAL ALLOW	224,059.15
NON-COVERD CHARGES	20,583.99	TOTAL MEDICAID LIAB	26,459.62
		LESS: COB	35.24
		LESS: COPAYMENT	831.04
		REIMBURSEMENT	25,593.34

TOTAL NUMBER OF CLAIMS 473

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,275.58	1,663.46
MED/SURG SUPPLY	3,960.38	391.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,322.68	0.00
CT SCAN	18,974.76	1,084.16
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,619.27	0.00
IV THERAPY	5,038.54	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	468.16	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	112,316.53	310.07
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,597.33	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	110.32	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,411.94	4,139.85
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/OBSERV. RM	527.19	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	404.77	404.77
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	55,861.09	11,611.01
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,630.23	978.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	250,518.77	20,583.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	250,518.77	20,583.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,143.21	ADJUSTMENTS	0.00
COVERED CHARGES	413,562.00	CONTRACTUAL ALLOW	303,892.26
NON-COVERD CHARGES	4,581.21	TOTAL MEDICAID LIAB	109,669.74
		LESS: COB	0.00
		LESS: COPAYMENT	585.00
		REIMBURSEMENT	109,084.74

TOTAL NUMBER OF CLAIMS 21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	365.56	0.00
MED/SURG SUPPLY	512.00	32.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	165,946.68	1,011.87
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,501.31	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	239,618.44	1,221.31
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	188.79	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	882.46	39.03
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,546.76	2,277.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	413,562.00	4,581.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	413,562.00	4,581.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONAL MEDICAL CENTER
PO BOX 690
MILLEDGEVILLE,GA 31059-0690

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,346,828.27	ADJUSTMENTS	42,591.04
COVERED CHARGES	1,332,254.70	CONTRACTUAL ALLOW	805,653.47
NON-COVERD CHARGES	14,573.57	TOTAL MEDICAID LIAB	526,601.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	526,601.23

TOTAL NUMBER OF ADMISSIONS 76

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	235	0	140,616.00	1,800.00
ROUTINE NURSERY	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	235	0	140,616.00	1,800.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	70	0	102,130.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	70	0	102,130.00	0.00
TOTAL ACCOMODATIONS	305	0	242,746.00	1,800.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,431.48	0.00
MED/SURG SUPPLY	273,876.00	31.00
LABORATORY-GENERAL	212,464.00	0.00
RADIOLOGY-DIAGNOSTIC	25,377.00	0.00
CT SCAN	26,271.00	12,641.00
PHYSICAL THERAPY	8,475.24	0.00
EKG/ECG	17,544.00	0.00
IV THERAPY	3,770.00	0.00
OPERATING ROOM	41,632.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40,781.00	0.00
ANESTHESIA	6,778.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	87,381.00	0.00
RECOVERY ROOM	6,810.00	0.00
LABORATORY PATHOLOGIC	1,285.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,878.58	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,486.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,937.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,660.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,600.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,087.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,212.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,536.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	135,236.40	101.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,089,508.70	12,773.57
TOTAL ACCOMODATIONS	242,746.00	1,800.00
TOTAL CHARGES	1,332,254.70	14,573.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,899,184.94	ADJUSTMENTS	30,471.03
COVERED CHARGES	1,674,217.16	CONTRACTUAL ALLOW	1,292,410.75
NON-COVERD CHARGES	224,967.78	TOTAL MEDICAID LIAB	381,806.41
		LESS: COB	439.70
		LESS: COPAYMENT	2,058.00
		REIMBURSEMENT	379,308.71
		ALL OTHER	337,559.60
		FEE SCHEDULE-LAB	38,267.47
		INJECTABLE DRUGS	3,481.64

TOTAL NUMBER OF CLAIMS 1,537

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,744.73	1,901.36
MED/SURG SUPPLY	72,368.43	10,026.58
LABORATORY-GENERAL	0.00	208.00
RADIOLOGY-DIAGNOSTIC	142,536.00	2,001.29
CT SCAN	126,608.00	22,735.00
PHYSICAL THERAPY	5,053.62	1,500.63
EKG/ECG	22,962.00	0.00
IV THERAPY	6,056.00	212.00
OPERATING ROOM	147,925.22	42,279.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,933.00	0.00
ANESTHESIA	24,688.00	693.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	433,399.00	2,849.00
RECOVERY ROOM	30,252.00	8,568.00
LABORATORY PATHOLOGIC	0.00	561.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,576.50	0.00
SPEECH PATHOLOGY	0.00	273.57
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	41,179.00	1,199.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,248.00	312.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,630.00	10,345.49
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,769.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,547.00	175.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,209.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	341,662.50	93,865.11
MRI SERVICES	113,702.00	5,846.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31,168.16	19,415.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,674,217.16	224,967.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,674,217.16	224,967.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,020.95	ADJUSTMENTS	0.00
COVERED CHARGES	6,142.95	CONTRACTUAL ALLOW	2,587.52
NON-COVERD CHARGES	2,878.00	TOTAL MEDICAID LIAB	3,555.43
		LESS: COB	3,549.43
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	109.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,222.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,722.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	867.00	156.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,038.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.37	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,643.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	91.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,142.95	2,878.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,142.95	2,878.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,289.73	ADJUSTMENTS	485.46
COVERED CHARGES	165,506.18	CONTRACTUAL ALLOW	152,584.04
NON-COVERD CHARGES	4,783.55	TOTAL MEDICAID LIAB	12,922.14
		LESS: COB	0.00
		LESS: COPAYMENT	480.02
		REIMBURSEMENT	12,442.12

TOTAL NUMBER OF CLAIMS 231

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,594.29	65.00
MED/SURG SUPPLY	2,219.04	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,482.00	0.00
CT SCAN	7,629.00	1,361.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	645.00	0.00
IV THERAPY	53.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	106,479.00	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 SERVICE	918.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,361.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,641.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,586.00	2,486.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,848.85	871.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	165,506.18	4,783.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	165,506.18	4,783.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,289.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,199.00	CONTRACTUAL ALLOW	889.07
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	309.93
		LESS: COB	303.93
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	232.00	90.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	955.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,199.00	90.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,199.00	90.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/11	THROUGH	12/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	231,368.00	ADJUSTMENTS	21,310.05
COVERED CHARGES	213,263.00	CONTRACTUAL ALLOW	95,695.95
NON-COVERD CHARGES	18,105.00	TOTAL MEDICAID LIAB	117,567.05
		LESS: COB	94.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	117,472.24

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	94	0	30,550.00	18,105.00
ROUTINE NURSERY	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	94	0	30,550.00	18,105.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	94	0	30,550.00	18,105.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,233.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,823.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,002.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,680.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,680.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,592.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,416.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,125.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,240.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	257.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,010.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,161.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,650.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,196.00	0.00			

TOTAL ANCILLARY	182,713.00	0.00
TOTAL ACCOMODATIONS	30,550.00	18,105.00
TOTAL CHARGES	213,263.00	18,105.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,652.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,652.00	CONTRACTUAL ALLOW	5,652.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	5,000.00
		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	2	0	650.00	0.00
ROUTINE NURSERY	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	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	650.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,939.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	342.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,853.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,162.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,636.00	0.00			

TOTAL ANCILLARY	10,002.00	0.00
TOTAL ACCOMODATIONS	650.00	0.00
TOTAL CHARGES	10,652.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	610,759.00	ADJUSTMENTS	64,628.11
COVERED CHARGES	556,689.00	CONTRACTUAL ALLOW	379,499.62
NON-COVERD CHARGES	54,070.00	TOTAL MEDICAID LIAB	177,189.38
		LESS: COB	0.00
		LESS: COPAYMENT	720.00
		REIMBURSEMENT	176,469.38
		ALL OTHER	148,680.51
		FEE SCHEDULE-LAB	22,704.51
		INJECTABLE DRUGS	5,084.36

TOTAL NUMBER OF CLAIMS 838

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,814.00	0.00
MED/SURG SUPPLY	14,169.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,478.00	160.00
CT SCAN	75,210.00	3,120.00
PHYSICAL THERAPY	3,829.00	1,706.00
EKG/ECG	12,224.00	0.00
IV THERAPY	354.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,321.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	175,761.00	1,495.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	539.00	154.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,934.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,716.00	461.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,600.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,233.00	736.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,516.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	143,470.00	44,479.00
MRI SERVICES	3,518.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,003.00	1,759.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	556,689.00	54,070.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	556,689.00	54,070.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,114.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,092.00	CONTRACTUAL ALLOW	870.25
NON-COVERD CHARGES	22.00	TOTAL MEDICAID LIAB	1,221.75
		LESS: COB	1,221.75
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	691.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	270.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	448.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	623.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,092.00	22.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,092.00	22.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,533.00	ADJUSTMENTS	1,349.62
COVERED CHARGES	65,211.00	CONTRACTUAL ALLOW	56,615.97
NON-COVERD CHARGES	2,322.00	TOTAL MEDICAID LIAB	8,595.03
		LESS: COB	53.82
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	8,244.21

TOTAL NUMBER OF CLAIMS 155

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,721.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	399.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,640.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,700.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,191.00	2,170.00
EKG/ECG	822.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,312.00	61.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,349.00	91.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	77.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	65,211.00	2,322.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,211.00	2,322.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,155.50	ADJUSTMENTS	0.00
COVERED CHARGES	146,588.00	CONTRACTUAL ALLOW	-5,829.64
NON-COVERD CHARGES	2,567.50	TOTAL MEDICAID LIAB	152,417.64
		LESS: COB	1,197.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	151,220.11

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	92	0	38,272.00	0.00
ROUTINE NURSERY	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	92	0	38,272.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	92	0	38,272.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,038.00	0.00
MED/SURG SUPPLY	8,478.80	48.00
LABORATORY-GENERAL	31,727.00	0.00
RADIOLOGY-DIAGNOSTIC	5,252.00	0.00
CT SCAN	3,683.00	1,496.00
PHYSICAL THERAPY	1,180.00	0.00
EKG/ECG	1,998.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,830.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,865.00	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 SERVICE	242.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	868.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,358.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,736.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	620.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,308.20	155.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	108,316.00	2,567.50
TOTAL ACCOMODATIONS	38,272.00	0.00
TOTAL CHARGES	146,588.00	2,567.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	427,479.51	ADJUSTMENTS	7,060.73
COVERED CHARGES	360,964.04	CONTRACTUAL ALLOW	174,862.88
NON-COVERD CHARGES	66,515.47	TOTAL MEDICAID LIAB	186,101.16
		LESS: COB	620.98
		LESS: COPAYMENT	1,056.00
		REIMBURSEMENT	184,424.18
		ALL OTHER	156,492.03
		FEE SCHEDULE-LAB	23,545.95
		INJECTABLE DRUGS	4,386.20

TOTAL NUMBER OF CLAIMS 689

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,102.40	801.00	OTHER LAB	3,200.00	280.00
MED/SURG SUPPLY	9,534.75	412.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,079.00	910.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,785.00	4,184.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	390.00	462.00	FEE SCHEDULE LAB	163,984.16	47,233.20
EKG/ECG	9,820.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,604.00	146.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,481.42	450.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,947.31	8,165.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	3,591.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,472.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,753.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,800.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,892.00	0.00			

TOTAL ANCILLARY	360,964.04	66,515.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	360,964.04	66,515.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,167.25	ADJUSTMENTS	0.00
COVERED CHARGES	7,543.25	CONTRACTUAL ALLOW	2,373.87
NON-COVERD CHARGES	2,624.00	TOTAL MEDICAID LIAB	5,169.38
		LESS: COB	5,142.38
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	407.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	733.00	700.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,435.25	1,033.00
EKG/ECG	166.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,495.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	197.00	891.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	576.00	0.00			

TOTAL ANCILLARY	7,543.25	2,624.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,543.25	2,624.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,698.90	ADJUSTMENTS	282.00
COVERED CHARGES	32,026.90	CONTRACTUAL ALLOW	26,176.90
NON-COVERD CHARGES	2,672.00	TOTAL MEDICAID LIAB	5,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	5,655.00

TOTAL NUMBER OF CLAIMS 117

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	459.90	0.00
MED/SURG SUPPLY	544.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	935.00	0.00
CT SCAN	1,281.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	932.00	0.00
IV THERAPY	0.00	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	17,815.00	15.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,541.00	2,150.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,231.00	507.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	32,026.90	2,672.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,026.90	2,672.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	399.00	ADJUSTMENTS	0.00
COVERED CHARGES	325.00	CONTRACTUAL ALLOW	54.84
NON-COVERD CHARGES	74.00	TOTAL MEDICAID LIAB	270.16
		LESS: COB	261.16
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	325.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	74.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	325.00	74.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	325.00	74.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
408 PEACOCK ST
COCHRAN,GA 31014-9427

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	412,039.20	ADJUSTMENTS	14,840.37
COVERED CHARGES	409,495.20	CONTRACTUAL ALLOW	239,959.23
NON-COVERD CHARGES	2,544.00	TOTAL MEDICAID LIAB	169,535.97
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	169,535.97

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	113	0	59,159.00	2,544.00
ROUTINE NURSERY	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	113	0	59,159.00	2,544.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	113	0	59,159.00	2,544.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,428.20	0.00
MED/SURG SUPPLY	24,873.00	0.00
LABORATORY-GENERAL	77,344.00	0.00
RADIOLOGY-DIAGNOSTIC	9,776.00	0.00
CT SCAN	30,612.00	0.00
PHYSICAL THERAPY	1,822.00	0.00
EKG/ECG	3,352.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,230.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,027.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,046.00	0.00
SPEECH PATHOLOGY	2,550.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	495.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,232.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,780.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	64.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	971.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,734.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	350,336.20	0.00
TOTAL ACCOMODATIONS	59,159.00	2,544.00
TOTAL CHARGES	409,495.20	2,544.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,547,827.00	ADJUSTMENTS	26,999.83
COVERED CHARGES	1,319,767.20	CONTRACTUAL ALLOW	949,863.13
NON-COVERD CHARGES	228,059.80	TOTAL MEDICAID LIAB	369,904.07
		LESS: COB	0.00
		LESS: COPAYMENT	2,475.00
		REIMBURSEMENT	367,429.07
		ALL OTHER	314,291.28
		FEE SCHEDULE-LAB	52,321.53
		INJECTABLE DRUGS	816.26

TOTAL NUMBER OF CLAIMS 1,714

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	367,961.20	10,093.00
MED/SURG SUPPLY	12,394.00	160.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,107.00	368.00
CT SCAN	93,099.00	77,317.00
PHYSICAL THERAPY	38,279.00	19,362.00
EKG/ECG	8,944.00	108.00
IV THERAPY	11,890.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,235.00	677.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	174,603.00	1,621.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	21,631.00	8,988.00
SPEECH PATHOLOGY	344.00	344.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,127.00	298.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,122.00	1,342.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,450.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,908.00	524.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,187.00	124.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	402,841.00	92,822.80
MRI SERVICES	28,887.00	3,393.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,758.00	10,518.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,319,767.20	228,059.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,319,767.20	228,059.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,087.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,939.00	CONTRACTUAL ALLOW	1,434.60
NON-COVERD CHARGES	148.00	TOTAL MEDICAID LIAB	2,504.40
		LESS: COB	2,504.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194.00	11.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	558.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,201.00	120.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,913.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	17.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,939.00	148.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,939.00	148.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,314.00	ADJUSTMENTS	545.01
COVERED CHARGES	52,679.00	CONTRACTUAL ALLOW	48,351.97
NON-COVERD CHARGES	4,635.00	TOTAL MEDICAID LIAB	4,327.03
		LESS: COB	16.31
		LESS: COPAYMENT	174.04
		REIMBURSEMENT	4,136.68

TOTAL NUMBER OF CLAIMS 87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,654.00	66.00
MED/SURG SUPPLY	583.00	0.00
LABORATORY-GENERAL	0.00	84.00
RADIOLOGY-DIAGNOSTIC	441.00	0.00
CT SCAN	2,861.00	1,219.00
PHYSICAL THERAPY	0.00	246.00
EKG/ECG	309.00	0.00
IV THERAPY	802.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	172.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,420.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	650.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	79.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,550.00	2,308.00
MRI SERVICES	1,334.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,474.00	62.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	52,679.00	4,635.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,679.00	4,635.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	119,396.20	ADJUSTMENTS	0.00
COVERED CHARGES	117,162.20	CONTRACTUAL ALLOW	95,760.75
NON-COVERD CHARGES	2,234.00	TOTAL MEDICAID LIAB	21,401.45
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	21,332.45

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,981.20	1,430.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,170.00	0.00
CT SCAN	2,464.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	108.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	748.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,691.00	804.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	117,162.20	2,234.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,162.20	2,234.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
PO BOX 5000
QUITMAN,GA 31643-5000

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,565,181.46	ADJUSTMENTS	73,897.68
COVERED CHARGES	19,273,670.64	CONTRACTUAL ALLOW	14,480,017.42
NON-COVERD CHARGES	291,510.82	TOTAL MEDICAID LIAB	4,793,653.22
		LESS: COB	50,533.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,743,119.63

TOTAL NUMBER OF ADMISSIONS 829

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,737	0	755,595.00	104,220.00
ROUTINE NURSERY	305	0	125,600.00	1,100.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	6,435.00
TOTAL ROUTINE	2,042	0	881,195.00	111,755.00
SPECIAL CARE SERVICES				
CCU	55	0	54,725.00	0.00
ICU	978	0	801,797.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,033	0	856,522.00	0.00
TOTAL ACCOMODATIONS	3,075	0	1,737,717.00	111,755.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,986,019.24	0.00
MED/SURG SUPPLY	4,125,550.92	3,347.58
LABORATORY-GENERAL	2,873,539.66	1,404.72
RADIOLOGY-DIAGNOSTIC	405,659.59	24,729.10
CT SCAN	1,164,246.73	198.66
PHYSICAL THERAPY	84,686.89	0.00
EKG/ECG	95,068.36	0.00
IV THERAPY	32,193.34	0.00
OPERATING ROOM	1,595,876.72	0.00
LABOR/DELIVERY ROOM	527,480.65	0.00
RESPIRATORY SERVICES	334,891.57	0.00
ANESTHESIA	376,293.42	0.00
GI SERVICES	139,232.04	0.00
EMERGENCY ROOM	725,593.95	0.00
RECOVERY ROOM	98,390.21	0.00
LABORATORY PATHOLOGIC	111,123.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,037.05	0.00
SPEECH PATHOLOGY	22,098.34	0.00
RENAL DIALYSIS	50,939.50	13,683.25
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	256.98	796.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	116,197.42	8,629.82
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	214,878.36	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	98,620.87	18,674.62
AUDIOLOGY	5,240.00	0.00
CARDIOLOGY	877,892.95	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,240.24	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,886.27	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	76,753.28	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	12,892.51	0.00
OTHER THERAPEUTIC SVC	0.00	10,720.35
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	329,173.23	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	4,263.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	93,307.76

TOTAL ANCILLARY	17,535,953.64	179,755.82
TOTAL ACCOMODATIONS	1,737,717.00	111,755.00
TOTAL CHARGES	19,273,670.64	291,510.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2010321031334	11/02/10 - 11/07/10	11/22/10	0.00	4,682.90	0.00	0.00	0.00
615	2010327032850	11/10/10 - 11/13/10	11/29/10	0.00	8,468.57	0.00	0.00	0.00
615	2010328042308	11/14/10 - 11/19/10	11/29/10	0.00	2,341.45	0.00	0.00	0.00
615	2010361001908	12/14/10 - 12/15/10	02/07/11	0.00	2,341.45	0.00	0.00	0.00
615	2011003003394	10/20/10 - 10/30/10	01/31/11	0.00	2,341.45	0.00	0.00	0.00
615	2211042012405	11/09/10 - 11/18/10	02/14/11	0.00	2,341.45	0.00	0.00	0.00
615	2011049046415	02/03/11 - 02/03/11	02/21/11	0.00	2,341.45	0.00	0.00	0.00
615	2011053021228	01/17/11 - 01/17/11	02/28/11	0.00	2,341.45	0.00	0.00	0.00
615	2011053020839	01/16/11 - 01/16/11	02/28/11	0.00	2,341.45	0.00	0.00	0.00
615	2011053020862	12/17/10 - 12/17/10	02/28/11	0.00	2,341.45	0.00	0.00	0.00
615	2011062047322	02/17/11 - 02/17/11	03/07/11	0.00	8,468.57	0.00	0.00	0.00
615	1111038007314	10/12/10 - 10/12/10	03/14/11	0.00	2,341.45	0.00	0.00	0.00
615	2011068019540	02/21/11 - 02/21/11	03/14/11	0.00	2,341.45	0.00	0.00	0.00
615	2011080012732	03/01/11 - 03/01/11	03/28/11	0.00	2,341.45	0.00	0.00	0.00
615	2011103029046	03/12/11 - 03/12/11	04/18/11	0.00	2,341.45	0.00	0.00	0.00
615	2011108003760	04/03/11 - 04/03/11	04/25/11	0.00	2,341.45	0.00	0.00	0.00
615	2011117013612	03/31/11 - 03/31/11	05/02/11	0.00	2,341.45	0.00	0.00	0.00
615	2011119033877	02/25/11 - 02/25/11	05/02/11	0.00	2,341.45	0.00	0.00	0.00
615	2011123020652	12/25/10 - 12/25/10	05/09/11	0.00	2,341.45	0.00	0.00	0.00
615	2011125052801	04/28/11 - 04/28/11	05/09/11	0.00	2,341.45	0.00	0.00	0.00
615	2011146030803	05/19/11 - 05/19/11	05/30/11	0.00	2,341.45	0.00	0.00	0.00
615	2011172027810	12/31/10 - 12/31/10	06/27/11	0.00	8,468.57	0.00	0.00	0.00
615	2011230042938	02/13/11 - 02/13/11	08/22/11	0.00	2,341.45	0.00	0.00	0.00
615	2011291028096	12/14/10 - 12/14/10	10/24/11	0.00	2,341.45	0.00	0.00	0.00
615	2211293021281	09/28/11 - 09/28/11	10/24/11	0.00	2,341.45	0.00	0.00	0.00
615	2011313007859	05/15/11 - 05/15/11	11/14/11	0.00	2,341.45	0.00	0.00	0.00
615	2011318050166	05/01/11 - 05/01/11	11/21/11	0.00	2,341.45	0.00	0.00	0.00
615	2011336010406	05/15/11 - 05/15/11	12/05/11	0.00	2,341.45	0.00	0.00	0.00
615	2011348033776	12/21/10 - 12/21/10	12/19/11	0.00	2,341.45	0.00	0.00	0.00
615	9112129003461	08/25/11 - 08/25/11	06/18/12	0.00	2,341.45	0.00	3,283.73	0.00
615	2012159078087	05/10/11 - 05/13/11	06/11/12	0.00	2,341.45	0.00	0.00	0.00
TOTAL				0.00	93,307.76	0.00	3,283.73	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,091.79	ADJUSTMENTS	0.00
COVERED CHARGES	29,671.79	CONTRACTUAL ALLOW	9,652.40
NON-COVERD CHARGES	420.00	TOTAL MEDICAID LIAB	20,019.39
		LESS: COB	20,019.39
		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	7	0	3,045.00	420.00
ROUTINE NURSERY	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	3,045.00	420.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	3,045.00	420.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,606.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,735.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,864.12	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	351.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,317.96	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	187.79	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,742.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	195.10	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	625.97	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,626.79	0.00
TOTAL ACCOMODATIONS	3,045.00	420.00
TOTAL CHARGES	29,671.79	420.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,197,310.11	ADJUSTMENTS	393,245.59
COVERED CHARGES	14,457,928.64	CONTRACTUAL ALLOW	11,697,746.88
NON-COVERD CHARGES	2,739,381.47	TOTAL MEDICAID LIAB	2,760,181.76
		LESS: COB	1,392.71
		LESS: COPAYMENT	5,868.00
		REIMBURSEMENT	2,752,921.05
		ALL OTHER	2,584,163.83
		FEE SCHEDULE-LAB	143,369.66
		INJECTABLE DRUGS	25,387.56

TOTAL NUMBER OF CLAIMS 5,601

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,423.41	94,236.32
MED/SURG SUPPLY	1,878,042.94	49,418.78
LABORATORY-GENERAL	0.00	5,224.15
RADIOLOGY-DIAGNOSTIC	673,204.51	75,584.37
CT SCAN	1,450,206.10	198,905.70
PHYSICAL THERAPY	0.00	3,226.22
EKG/ECG	83,349.35	330.09
IV THERAPY	35,131.17	191.02
OPERATING ROOM	585,701.76	402,486.88
LABOR/DELIVERY ROOM	1,481.46	0.00
RESPIRATORY SERVICES	582,479.35	25,697.11
ANESTHESIA	382,379.83	58,136.33
GI SERVICES	150,611.03	51,305.56
EMERGENCY ROOM	2,909,743.28	25,352.15
RECOVERY ROOM	239,929.48	5,821.22
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,102.41
SPEECH PATHOLOGY	0.00	2,876.21
RENAL DIALYSIS	0.00	9,695.85
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	5,006.10
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	358,688.31	59,748.13
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	46,138.45	12,405.74
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	165,721.48	42,406.44
AUDIOLOGY	0.00	0.00
CARDIOLOGY	473,486.42	617,040.22
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,600.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	591,425.71	3,647.41

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	512,408.95	25,039.12
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	498.94	631.98
OTHER THERAPEUTIC SVC	0.00	99,115.16
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,281,892.61	457,517.42
MRI SERVICES	388,962.40	64,074.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	602,421.60	343,159.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,457,928.64	2,739,381.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,457,928.64	2,739,381.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	531,800.66	ADJUSTMENTS	0.00
COVERED CHARGES	413,939.32	CONTRACTUAL ALLOW	131,554.59
NON-COVERD CHARGES	117,861.34	TOTAL MEDICAID LIAB	282,384.73
		LESS: COB	282,233.23
		LESS: COPAYMENT	151.50
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,012.34	632.68
MED/SURG SUPPLY	97,605.68	392.76
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,216.76	1,942.00
CT SCAN	4,166.21	6,818.17
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,860.36	0.00
IV THERAPY	1,037.87	0.00
OPERATING ROOM	24,474.16	14,166.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,513.39	0.00
ANESTHESIA	16,032.50	0.00
GI SERVICES	0.00	2,671.71
EMERGENCY ROOM	89,698.80	725.22
RECOVERY ROOM	10,574.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	13.65
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	820.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	128.49
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,699.65	16,621.66
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,370.00	841.08
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,767.06	17,322.46
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,260.01	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,408.37	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,151.48	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	26.26	0.00
OTHER THERAPEUTIC SVC	0.00	903.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	74,528.27	23,975.75
MRI SERVICES	14,832.10	9,189.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,704.05	20,696.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	413,939.32	117,861.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	413,939.32	117,861.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,653,782.89	ADJUSTMENTS	1,273.52
COVERED CHARGES	1,534,421.29	CONTRACTUAL ALLOW	1,481,042.12
NON-COVERD CHARGES	119,361.60	TOTAL MEDICAID LIAB	53,379.17
		LESS: COB	0.00
		LESS: COPAYMENT	1,680.06
		REIMBURSEMENT	51,699.11

TOTAL NUMBER OF CLAIMS 954

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,632.45	20,169.79
MED/SURG SUPPLY	59,705.51	1,316.35
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,993.91	346.45
CT SCAN	117,218.43	33,894.24
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,861.26	0.00
IV THERAPY	3,364.18	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,298.66	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	871,714.64	3,088.16
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	303.23
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	30,814.48	10,472.67
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	656.00	228.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,556.43	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/OBSERV. RM	3,130.43	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,006.47	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	26.26	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	257,721.45	33,231.10
MRI SERVICES	13,482.92	2,341.45
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,237.81	13,970.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,534,421.29	119,361.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,534,421.29	119,361.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,720.59	ADJUSTMENTS	0.00
COVERED CHARGES	55,770.82	CONTRACTUAL ALLOW	17,142.27
NON-COVERD CHARGES	13,949.77	TOTAL MEDICAID LIAB	38,628.55
		LESS: COB	38,607.55
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	659.74	5.00
MED/SURG SUPPLY	3,428.03	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,224.95	0.00
CT SCAN	3,275.40	6,818.17
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	660.18	0.00
IV THERAPY	424.46	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	27,240.75	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 SERVICE	1,505.44	1,470.86
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,720.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,630.99	2,240.32
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,415.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	55,770.82	13,949.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,770.82	13,949.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,936,596.08	ADJUSTMENTS	125,872.53
COVERED CHARGES	5,311,043.01	CONTRACTUAL ALLOW	4,539,721.71
NON-COVERD CHARGES	625,553.07	TOTAL MEDICAID LIAB	771,321.30
		LESS: COB	12,760.15
		LESS: COPAYMENT	731.64
		REIMBURSEMENT	757,829.51

TOTAL NUMBER OF CLAIMS 151

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,424.91	19,853.14
MED/SURG SUPPLY	2,520,435.28	1,545.16
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,883.64	21,221.88
CT SCAN	27,644.14	23,379.68
PHYSICAL THERAPY	0.00	848.36
EKG/ECG	13,818.19	0.00
IV THERAPY	116.72	0.00
OPERATING ROOM	1,234,062.78	265,492.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,404.78	0.00
ANESTHESIA	353,662.40	0.00
GI SERVICES	2,671.71	0.00
EMERGENCY ROOM	30,175.44	323.84
RECOVERY ROOM	185,475.06	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,640.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	242.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	21,886.00	0.00
OTHER IMAGING SERVICE	4,586.04	2,206.29
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,312.00	228.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,569.09	4,564.36
AUDIOLOGY	0.00	0.00
CARDIOLOGY	355,200.61	56,526.45
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	111,019.68	1,335.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,823.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	26.26	173.52
OTHER THERAPEUTIC SVC	0.00	7,361.77
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	193,609.38	54,095.35
MRI SERVICES	3,467.71	8,215.41
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	150,767.93	156,300.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,311,043.01	625,553.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,311,043.01	625,553.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GEORGIA MEDICAL CENTER
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	683,736.99	ADJUSTMENTS	107,075.68
COVERED CHARGES	683,083.49	CONTRACTUAL ALLOW	65,610.30
NON-COVERD CHARGES	653.50	TOTAL MEDICAID LIAB	617,473.19
		LESS: COB	4,440.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	613,032.93

TOTAL NUMBER OF ADMISSIONS 158

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	398	0	127,360.00	0.00
ROUTINE NURSERY	43	0	7,955.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	441	0	135,315.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	441	0	135,315.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,810.56	0.00
MED/SURG SUPPLY	121,851.58	0.00
LABORATORY-GENERAL	75,018.60	0.00
RADIOLOGY-DIAGNOSTIC	16,480.00	0.00
CT SCAN	15,285.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,611.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,274.75	0.00
LABOR/DELIVERY ROOM	18,235.00	0.00
RESPIRATORY SERVICES	48,755.00	0.00
ANESTHESIA	21,587.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	35,969.50	0.00
RECOVERY ROOM	2,450.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	113.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,482.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,860.00	540.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,407.00	0.00
CARDIOLOGY	1,600.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,740.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	350.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	547,768.49	653.50
TOTAL ACCOMODATIONS	135,315.00	0.00
TOTAL CHARGES	683,083.49	653.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,734.15	ADJUSTMENTS	0.00
COVERED CHARGES	10,734.15	CONTRACTUAL ALLOW	4,860.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,873.43
		LESS: COB	5,873.43
		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	6	0	1,920.00	0.00
ROUTINE NURSERY	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	1,920.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	1,920.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,403.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,776.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,169.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,116.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	222.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	342.50	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,814.15	0.00
TOTAL ACCOMODATIONS	1,920.00	0.00
TOTAL CHARGES	10,734.15	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	701,170.92	ADJUSTMENTS	111,185.88
COVERED CHARGES	646,621.12	CONTRACTUAL ALLOW	307,039.47
NON-COVERD CHARGES	54,549.80	TOTAL MEDICAID LIAB	339,581.65
		LESS: COB	419.15
		LESS: COPAYMENT	1,416.00
		REIMBURSEMENT	337,746.50
		ALL OTHER	310,356.80
		FEE SCHEDULE-LAB	26,981.14
		INJECTABLE DRUGS	408.56

TOTAL NUMBER OF CLAIMS 1,375

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,714.35	3,643.58
MED/SURG SUPPLY	88,507.70	395.12
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,900.00	830.00
CT SCAN	49,260.00	8,730.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,075.50	536.00
IV THERAPY	275.00	0.00
OPERATING ROOM	33,575.00	11,455.00
LABOR/DELIVERY ROOM	8,005.00	250.00
RESPIRATORY SERVICES	16,673.50	265.00
ANESTHESIA	8,562.50	160.00
GI SERVICES	1,750.00	0.00
EMERGENCY ROOM	144,952.25	1,405.00
RECOVERY ROOM	5,600.00	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	4,132.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	30,572.50	4,257.50
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	67.00
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/OBSERV. RM	47,255.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,210.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	89,386.32	18,828.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,814.00	3,727.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	646,621.12	54,549.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	646,621.12	54,549.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,535.03	ADJUSTMENTS	1,860.52
COVERED CHARGES	35,462.53	CONTRACTUAL ALLOW	25,811.11
NON-COVERD CHARGES	1,072.50	TOTAL MEDICAID LIAB	9,651.42
		LESS: COB	59.76
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	9,264.66

TOTAL NUMBER OF CLAIMS 177

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,955.72	471.00
MED/SURG SUPPLY	1,459.01	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,435.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	412.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00
RESPIRATORY SERVICES	92.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,705.00	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 SERVICE	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,745.80	505.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,063.00	56.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,462.53	1,072.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,462.53	1,072.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,623.43	ADJUSTMENTS	0.00
COVERED CHARGES	8,379.43	CONTRACTUAL ALLOW	3,608.75
NON-COVERD CHARGES	244.00	TOTAL MEDICAID LIAB	4,770.68
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,767.68

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56.00	0.00
MED/SURG SUPPLY	5,494.43	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	2,475.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	137.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	116.50	15.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	229.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,379.43	244.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,379.43	244.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,096,964.55	ADJUSTMENTS	3,016,797.33
COVERED CHARGES	45,015,583.55	CONTRACTUAL ALLOW	25,996,310.51
NON-COVERD CHARGES	1,081,381.00	TOTAL MEDICAID LIAB	19,019,273.04
		LESS: COB	125,699.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,893,573.81

TOTAL NUMBER OF ADMISSIONS 3,469

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,004	14	5,547,824.00	436,970.00
ROUTINE NURSERY	2,825	18	2,074,811.00	73,102.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	12	0.00	0.00
TOTAL ROUTINE	9,829	44	7,622,635.00	510,072.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,795	1	2,793,684.00	1,211.00
NICU	1,598	0	3,004,067.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	355.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,393	12	5,797,751.00	1,566.00
TOTAL ACCOMODATIONS	13,222	56	13,420,386.00	511,638.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,328,434.00	7,085.00
MED/SURG SUPPLY	1,227,637.00	20,836.00
LABORATORY-GENERAL	3,777,443.75	6,240.00
RADIOLOGY-DIAGNOSTIC	1,729,617.00	0.00
CT SCAN	2,709,663.00	120,870.00
PHYSICAL THERAPY	199,927.00	6,570.00
EKG/ECG	200,837.00	0.00
IV THERAPY	91,005.00	282.00
OPERATING ROOM	4,168,530.00	15,024.00
LABOR/DELIVERY ROOM	576,649.80	0.00
RESPIRATORY SERVICES	1,187,061.00	17,541.00
ANESTHESIA	1,604,287.00	1,190.00
GI SERVICES	226,544.00	0.00
EMERGENCY ROOM	1,712,176.00	29,459.00
RECOVERY ROOM	1,201,122.00	1,978.00
LABORATORY PATHOLOGIC	243,944.00	802.00
RADIOLOGY THERAPEUTIC	1,800.00	0.00
OCCUPATIONAL THERAPY	63,938.00	2,869.00
SPEECH PATHOLOGY	44,409.00	2,899.00
RENAL DIALYSIS	26,400.00	238,412.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,518.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	16,000.00	0.00
OTHER IMAGING SERVICE	429,476.00	20,595.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	698,994.00	10,062.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	272,118.00	524.00
AUDIOLOGY	135,754.00	0.00
CARDIOLOGY	858,773.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	29,224.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	28,538.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	346,947.00	130.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,972.00	102.00
OTHER THERAPEUTIC SVC	0.00	5,590.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	601,346.00	24,291.00
PROFESSIONAL FEES	0.00	475.00
DURABLE MED. EQUIP.	0.00	1,412.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,846,631.00	3,933.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	24,429.00
NO CC/INVALID REV CODE	0.00	2,625.00

TOTAL ANCILLARY	31,595,197.55	569,743.00
TOTAL ACCOMODATIONS	13,420,386.00	511,638.00
TOTAL CHARGES	45,015,583.55	1,081,381.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2311024000030	09/28/10 - 10/05/10	01/31/11	0.00	2,625.00	0.00	0.00	0.00
-1	2311158000014	03/05/11 - 03/08/11	08/08/11	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	2,625.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	405,312.25	ADJUSTMENTS	0.00
COVERED CHARGES	404,086.25	CONTRACTUAL ALLOW	138,715.59
NON-COVERD CHARGES	1,226.00	TOTAL MEDICAID LIAB	265,370.66
		LESS: COB	265,370.66
		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	29	0	23,664.00	1,189.00
ROUTINE NURSERY	4	0	3,690.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	27,354.00	1,189.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	8	0	10,966.00	0.00
NICU	34	0	153,180.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	42	0	164,146.00	0.00
TOTAL ACCOMODATIONS	75	0	191,500.00	1,189.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,533.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,655.00	37.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,787.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,661.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,274.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	266.00	0.00	MRI SERVICES	3,014.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,282.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,296.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,021.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,158.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,948.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	484.00	0.00	INJECTABLE DRUGS	5,102.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	232.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	344.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,426.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,494.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	89.00	0.00			
CARDIOLOGY	1,400.00	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	212,586.25	37.00
TOTAL ACCOMODATIONS	191,500.00	1,189.00
TOTAL CHARGES	404,086.25	1,226.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,966,520.94	ADJUSTMENTS	676,549.80
COVERED CHARGES	17,567,606.08	CONTRACTUAL ALLOW	13,952,322.43
NON-COVERD CHARGES	3,398,914.86	TOTAL MEDICAID LIAB	3,615,283.65
		LESS: COB	4,612.57
		LESS: COPAYMENT	8,401.40
		REIMBURSEMENT	3,602,269.68
		ALL OTHER	3,147,240.70
		FEE SCHEDULE-LAB	272,021.37
		INJECTABLE DRUGS	183,007.61

TOTAL NUMBER OF CLAIMS 10,223

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	933,890.00	21,220.00
MED/SURG SUPPLY	101,616.00	195,465.00
LABORATORY-GENERAL	0.00	8,284.00
RADIOLOGY-DIAGNOSTIC	1,013,589.00	53,391.00
CT SCAN	1,962,778.00	740,476.00
PHYSICAL THERAPY	15,172.00	1,359.00
EKG/ECG	232,405.00	1,715.00
IV THERAPY	265,409.00	15,849.00
OPERATING ROOM	1,569,103.00	671,069.00
LABOR/DELIVERY ROOM	110,018.00	1,145.00
RESPIRATORY SERVICES	79,273.00	36,421.00
ANESTHESIA	604,425.00	1,742.00
GI SERVICES	195,036.00	49,876.00
EMERGENCY ROOM	3,438,101.00	80,913.00
RECOVERY ROOM	786,905.00	901.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	91,933.00	3,222.00
OCCUPATIONAL THERAPY	7,018.00	3,842.00
SPEECH PATHOLOGY	170.00	650.00
RENAL DIALYSIS	800.00	16,800.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	238,173.00	2,862.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	80,000.00	0.00
OTHER IMAGING SERVICE	1,161,349.00	58,263.00
BLOOD	134.00	0.00
BLOOD STORAGE & PRO.	42,851.00	26,840.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	268,106.00	124,132.00
AUDIOLOGY	89.00	0.00
CARDIOLOGY	206,445.00	184,312.00
AMBULATORY SURGERY	555.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,220.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	160,275.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	187,509.00	21,292.00
RECREATIONAL THERAPY	650.00	0.00
EDUCATION & TRAINING	386.00	420.00
OTHER THERAPEUTIC SVC	0.00	16,366.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,454,185.08	387,969.86
MRI SERVICES	452,256.00	45,813.00
PROFESSIONAL FEES	0.00	255.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	899,782.00	616,650.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	1,437.00
NO CC/INVALID REV CODE	0.00	9.00

TOTAL ANCILLARY	17,567,606.08	3,390,960.86
TOTAL ACCOMODATIONS	0.00	7,954.00
TOTAL CHARGES	17,567,606.08	3,398,914.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8296	5911173001213	02/28/11 - 02/28/11	06/27/11	0.00	9.00	0.00	0.00	0.00
TOTAL				0.00	9.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	223,127.00	ADJUSTMENTS	0.00
COVERED CHARGES	157,514.00	CONTRACTUAL ALLOW	92,328.13
NON-COVERD CHARGES	65,613.00	TOTAL MEDICAID LIAB	65,185.87
		LESS: COB	65,097.28
		LESS: COPAYMENT	88.59
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,174.00	88.00
MED/SURG SUPPLY	775.00	3,881.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,450.00	2,432.00
CT SCAN	4,897.00	10,694.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,596.00	0.00
IV THERAPY	5,101.00	0.00
OPERATING ROOM	10,540.00	12,453.00
LABOR/DELIVERY ROOM	2,060.00	0.00
RESPIRATORY SERVICES	1,639.00	425.00
ANESTHESIA	6,491.00	0.00
GI SERVICES	0.00	1,954.00
EMERGENCY ROOM	29,647.00	1,094.00
RECOVERY ROOM	9,342.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	596.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,676.00	8,317.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,089.00	1,270.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,282.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	722.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,262.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,886.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	650.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,554.00	1,764.00
MRI SERVICES	0.00	2,900.00
PROFESSIONAL FEES	0.00	189.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,017.00	15,891.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	157,514.00	65,284.00
TOTAL ACCOMODATIONS	0.00	329.00
TOTAL CHARGES	157,514.00	65,613.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	761,215.75	ADJUSTMENTS	4,432.12
COVERED CHARGES	686,877.25	CONTRACTUAL ALLOW	645,873.23
NON-COVERD CHARGES	74,338.50	TOTAL MEDICAID LIAB	41,004.02
		LESS: COB	51.84
		LESS: COPAYMENT	765.02
		REIMBURSEMENT	40,187.16

TOTAL NUMBER OF CLAIMS 733

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,879.00	298.00
MED/SURG SUPPLY	1,512.00	2,429.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,578.00	788.00
CT SCAN	28,652.00	23,662.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,778.00	266.00
IV THERAPY	0.00	107.00
OPERATING ROOM	0.00	41.00
LABOR/DELIVERY ROOM	2,923.00	359.00
RESPIRATORY SERVICES	1,010.00	268.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	379,501.00	6,946.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,600.00
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 SERVICE	37,083.00	3,078.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	846.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,356.00	3,840.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	140.00
OTHER THERAPEUTIC SVC	0.00	260.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	141,366.25	21,998.50
MRI SERVICES	0.00	3,971.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,313.00	4,225.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	686,877.25	74,276.50
TOTAL ACCOMODATIONS	0.00	62.00
TOTAL CHARGES	686,877.25	74,338.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,286.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,016.00	CONTRACTUAL ALLOW	3,816.45
NON-COVERD CHARGES	270.00	TOTAL MEDICAID LIAB	3,199.55
		LESS: COB	3,196.55
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,678.00	270.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,982.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,032.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,016.00	270.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,016.00	270.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,118,669.12	ADJUSTMENTS	117,942.20
COVERED CHARGES	1,882,569.80	CONTRACTUAL ALLOW	1,444,576.15
NON-COVERD CHARGES	236,099.32	TOTAL MEDICAID LIAB	437,993.65
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	437,429.65

TOTAL NUMBER OF CLAIMS 87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162,018.00	2,290.00
MED/SURG SUPPLY	68,946.00	25,940.00
LABORATORY-GENERAL	0.00	97.00
RADIOLOGY-DIAGNOSTIC	11,972.00	2,743.00
CT SCAN	12,064.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,596.00	0.00
IV THERAPY	59,085.00	476.00
OPERATING ROOM	178,337.00	371.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	451.00	0.00
ANESTHESIA	45,234.00	0.00
GI SERVICES	3,661.00	0.00
EMERGENCY ROOM	22,257.00	0.00
RECOVERY ROOM	52,417.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	75,358.00	1,530.00
OCCUPATIONAL THERAPY	0.00	194.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	800.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	16,000.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	26,171.00	8,169.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,550.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,991.00	7,560.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	896.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,557.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,615.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,543.00	4,186.00
MRI SERVICES	7,942.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,066,458.80	180,193.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,882,569.80	236,099.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,882,569.80	236,099.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	372,836.00	ADJUSTMENTS	24,927.01
COVERED CHARGES	369,955.00	CONTRACTUAL ALLOW	146,458.58
NON-COVERD CHARGES	2,881.00	TOTAL MEDICAID LIAB	223,496.42
		LESS: COB	10,665.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	212,831.01

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	131	0	58,890.00	453.00
ROUTINE NURSERY	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	131	0	58,890.00	453.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	131	0	58,890.00	453.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,589.00	0.00
MED/SURG SUPPLY	47,334.00	0.00
LABORATORY-GENERAL	59,829.00	0.00
RADIOLOGY-DIAGNOSTIC	5,132.00	0.00
CT SCAN	45,249.00	0.00
PHYSICAL THERAPY	2,295.00	0.00
EKG/ECG	1,635.00	0.00
IV THERAPY	3,135.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,222.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,099.00	0.00
EMERGENCY ROOM	8,250.00	0.00
RECOVERY ROOM	728.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	168.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,960.00	0.00
BLOOD	5,408.00	0.00
BLOOD STORAGE & PRO.	0.00	278.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,282.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,934.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,631.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,185.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,150.00

TOTAL ANCILLARY	311,065.00	2,428.00
TOTAL ACCOMODATIONS	58,890.00	453.00
TOTAL CHARGES	369,955.00	2,881.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	4010267071129	09/20/10 - 09/20/10	10/04/10	0.00	2,150.00	0.00	0.00	0.00
TOTAL				0.00	2,150.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,316.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,316.00	CONTRACTUAL ALLOW	10,041.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,274.40
		LESS: COB	4,274.40
		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	2	0	906.00	0.00
ROUTINE NURSERY	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	906.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	906.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,786.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	772.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,188.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	560.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,994.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	209.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,114.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	455.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	182.00	0.00			

TOTAL ANCILLARY	13,410.00	0.00
TOTAL ACCOMODATIONS	906.00	0.00
TOTAL CHARGES	14,316.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	363,683.00	ADJUSTMENTS	22,939.37
COVERED CHARGES	314,441.00	CONTRACTUAL ALLOW	181,984.67
NON-COVERD CHARGES	49,242.00	TOTAL MEDICAID LIAB	132,456.33
		LESS: COB	94.62
		LESS: COPAYMENT	732.00
		REIMBURSEMENT	131,629.71
		ALL OTHER	115,629.22
		FEE SCHEDULE-LAB	15,699.64
		INJECTABLE DRUGS	300.85

TOTAL NUMBER OF CLAIMS 496

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,530.00	180.00
MED/SURG SUPPLY	14,934.00	76.00
LABORATORY-GENERAL	0.00	417.00
RADIOLOGY-DIAGNOSTIC	13,561.00	126.00
CT SCAN	52,853.00	10,389.00
PHYSICAL THERAPY	888.00	0.00
EKG/ECG	4,581.00	0.00
IV THERAPY	5,643.00	627.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,957.00	450.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,182.00	3,847.00
EMERGENCY ROOM	31,095.00	292.00
RECOVERY ROOM	1,092.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,605.00	0.00
BLOOD	1,248.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	594.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,775.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,322.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,928.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,341.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,967.00	29,480.00
MRI SERVICES	3,522.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	98.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,725.00	1,934.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	65.00

TOTAL ANCILLARY	314,441.00	47,883.00
TOTAL ACCOMODATIONS	0.00	1,359.00
TOTAL CHARGES	314,441.00	49,242.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3301	2210308002983	10/29/10 - 10/29/10	11/08/10	0.00	65.00	0.00	0.00	0.00
TOTAL				0.00	65.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,377.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,237.00	CONTRACTUAL ALLOW	543.75
NON-COVERD CHARGES	140.00	TOTAL MEDICAID LIAB	693.25
		LESS: COB	690.25
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	660.00	140.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	305.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,237.00	140.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,237.00	140.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,151.00	ADJUSTMENTS	243.99
COVERED CHARGES	31,497.00	CONTRACTUAL ALLOW	27,247.00
NON-COVERD CHARGES	4,654.00	TOTAL MEDICAID LIAB	4,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	174.01
		REIMBURSEMENT	4,075.99

TOTAL NUMBER OF CLAIMS 85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,852.00	202.00
MED/SURG SUPPLY	542.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,383.00	0.00
CT SCAN	4,944.00	3,296.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	327.00	0.00
IV THERAPY	418.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	60.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,651.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,795.00	1,043.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	525.00	113.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	31,497.00	4,654.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,497.00	4,654.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	266.00	ADJUSTMENTS	0.00
COVERED CHARGES	266.00	CONTRACTUAL ALLOW	141.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	124.36
		LESS: COB	124.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	120.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	266.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	266.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
PO BOX R
ARLINGTON,GA 39813-0496

PROVIDER NUMBER
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	989,231.15	ADJUSTMENTS	5,736.17
COVERED CHARGES	907,054.05	CONTRACTUAL ALLOW	392,900.56
NON-COVERD CHARGES	82,177.10	TOTAL MEDICAID LIAB	514,153.49
		LESS: COB	8,625.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	505,527.73

TOTAL NUMBER OF ADMISSIONS 94

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	335	0	126,280.00	81,770.00
ROUTINE NURSERY	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	335	0	126,280.00	81,770.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	67	0	89,206.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	67	0	89,206.00	0.00
TOTAL ACCOMODATIONS	402	0	215,486.00	81,770.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160,850.82	0.00	OTHER LAB	598.00	0.00
MED/SURG SUPPLY	82,282.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	159,546.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,191.00	0.00	OTHER THERAPEUTIC SVC	45.00	0.00
CT SCAN	85,722.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,106.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,286.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,451.29	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,080.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80,182.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,120.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,640.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,799.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,397.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	163.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	407.10
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	4,715.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,461.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,315.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,616.00	0.00			

TOTAL ANCILLARY	691,568.05	407.10
TOTAL ACCOMODATIONS	215,486.00	81,770.00
TOTAL CHARGES	907,054.05	82,177.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,423,336.63	ADJUSTMENTS	17,330.43
COVERED CHARGES	1,290,123.82	CONTRACTUAL ALLOW	744,636.01
NON-COVERD CHARGES	133,212.81	TOTAL MEDICAID LIAB	545,487.81
		LESS: COB	487.57
		LESS: COPAYMENT	1,587.00
		REIMBURSEMENT	543,413.24
		ALL OTHER	516,574.88
		FEE SCHEDULE-LAB	26,782.31
		INJECTABLE DRUGS	56.05

TOTAL NUMBER OF CLAIMS 1,239

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,041.17	1,372.53	OTHER LAB	1,898.00	1,612.00
MED/SURG SUPPLY	91,864.30	592.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	52.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,613.00	6,921.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,985.00	33,325.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,317.00	10,032.00	FEE SCHEDULE LAB	267,106.15	65,515.78
EKG/ECG	14,722.00	0.00	MRI SERVICES	44,187.00	0.00
IV THERAPY	6,559.36	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	192,259.00	9,641.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,577.00	268.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,775.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,888.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	200,747.85	1,752.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,092.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	587.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	112.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	23,197.00	650.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,170.00	780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,534.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,594.66	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,888.23	0.00			

TOTAL ANCILLARY	1,290,123.82	133,212.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,290,123.82	133,212.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	708.00	ADJUSTMENTS	0.00
COVERED CHARGES	118.00	CONTRACTUAL ALLOW	-9.50
NON-COVERD CHARGES	590.00	TOTAL MEDICAID LIAB	127.50
		LESS: COB	127.50
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118.00	590.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	118.00	590.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118.00	590.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	105,146.97	ADJUSTMENTS	99.98
COVERED CHARGES	99,174.97	CONTRACTUAL ALLOW	89,224.97
NON-COVERD CHARGES	5,972.00	TOTAL MEDICAID LIAB	9,950.00
		LESS: COB	0.02
		LESS: COPAYMENT	384.00
		REIMBURSEMENT	9,565.98

TOTAL NUMBER OF CLAIMS 199

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,379.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,220.00	26.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	39.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,465.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,125.00	2,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,111.00	3,307.00
EKG/ECG	538.00	0.00	MRI SERVICES	5,382.00	0.00
IV THERAPY	1,056.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	370.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,387.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	141.30	0.00			

TOTAL ANCILLARY	99,174.97	5,972.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,174.97	5,972.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	85,825.73	ADJUSTMENTS	0.00
COVERED CHARGES	81,909.73	CONTRACTUAL ALLOW	55,067.77
NON-COVERD CHARGES	3,916.00	TOTAL MEDICAID LIAB	26,841.96
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	26,826.96

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	823.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	36,499.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,322.00	2,666.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262.00	0.00
EKG/ECG	152.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,192.00	1,100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,087.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,571.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	150.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	81,909.73	3,916.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,909.73	3,916.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
PO BOX 597
METTER,GA 30439-0597

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,543,373.54	ADJUSTMENTS	2,389,948.20
COVERED CHARGES	26,286,789.14	CONTRACTUAL ALLOW	18,937,965.50
NON-COVERD CHARGES	256,584.40	TOTAL MEDICAID LIAB	7,348,823.64
		LESS: COB	132,808.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,216,014.96

TOTAL NUMBER OF ADMISSIONS 876

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,642	23	3,001,295.00	18,952.00
ROUTINE NURSERY	502	0	439,293.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,144	23	3,440,588.00	18,952.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,485	0	2,532,087.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,485	0	2,532,087.00	0.00
TOTAL ACCOMODATIONS	5,629	23	5,972,675.00	18,952.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,175,740.14	100.00
MED/SURG SUPPLY	1,303,736.00	13,827.40
LABORATORY-GENERAL	2,430,100.00	11,127.00
RADIOLOGY-DIAGNOSTIC	995,362.00	0.00
CT SCAN	804,883.00	14,831.00
PHYSICAL THERAPY	237,269.00	0.00
EKG/ECG	72,087.00	0.00
IV THERAPY	236,459.00	7,894.00
OPERATING ROOM	1,932,263.00	14,354.00
LABOR/DELIVERY ROOM	567,866.00	0.00
RESPIRATORY SERVICES	1,323,518.00	0.00
ANESTHESIA	487,630.00	0.00
GI SERVICES	91,656.00	0.00
EMERGENCY ROOM	532,315.00	756.00
RECOVERY ROOM	198,350.00	0.00
LABORATORY PATHOLOGIC	103,192.00	0.00
RADIOLOGY THERAPEUTIC	2,302.00	1,066.00
OCCUPATIONAL THERAPY	93,582.00	0.00
SPEECH PATHOLOGY	100,966.00	0.00
RENAL DIALYSIS	151,636.00	34,310.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	145,668.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	792,485.00	66,218.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	74,960.00	60,079.00
AUDIOLOGY	1,400.00	0.00
CARDIOLOGY	145,637.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	29,557.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	100,949.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	72,235.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	13,070.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	240,058.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,870,253.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,314,114.14	237,632.40
TOTAL ACCOMODATIONS	5,972,675.00	18,952.00
TOTAL CHARGES	26,286,789.14	256,584.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	193,716.00	ADJUSTMENTS	0.00
COVERED CHARGES	193,482.00	CONTRACTUAL ALLOW	133,304.86
NON-COVERD CHARGES	234.00	TOTAL MEDICAID LIAB	60,177.14
		LESS: COB	60,177.14
		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	39	0	32,136.00	0.00
ROUTINE NURSERY	8	0	5,046.00	234.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	37,182.00	234.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	47	0	37,182.00	234.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,878.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23,817.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,410.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,713.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,786.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	121.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	537.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,951.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,865.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	496.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,546.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,688.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,929.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	704.00	0.00	INJECTABLE DRUGS	15,382.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,271.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	156,300.00	0.00
TOTAL ACCOMODATIONS	37,182.00	234.00
TOTAL CHARGES	193,482.00	234.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,274,936.42	ADJUSTMENTS	739,677.63
COVERED CHARGES	11,975,936.39	CONTRACTUAL ALLOW	9,407,138.82
NON-COVERD CHARGES	1,299,000.03	TOTAL MEDICAID LIAB	2,568,797.57
		LESS: COB	18,341.12
		LESS: COPAYMENT	9,116.35
		REIMBURSEMENT	2,541,340.10
		ALL OTHER	1,923,747.73
		FEE SCHEDULE-LAB	404,208.76
		INJECTABLE DRUGS	213,383.61

TOTAL NUMBER OF CLAIMS 8,276

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	632,583.00	144,226.00
MED/SURG SUPPLY	588,775.76	26,877.00
LABORATORY-GENERAL	0.00	30.00
RADIOLOGY-DIAGNOSTIC	638,297.00	17,906.00
CT SCAN	934,664.50	85,561.00
PHYSICAL THERAPY	74,970.00	10,384.00
EKG/ECG	58,085.00	242.00
IV THERAPY	477,264.00	29,169.00
OPERATING ROOM	1,199,447.98	231,766.09
LABOR/DELIVERY ROOM	117,824.00	7,364.00
RESPIRATORY SERVICES	55,908.00	3,646.00
ANESTHESIA	284,885.00	4,537.00
GI SERVICES	80,491.00	1,273.00
EMERGENCY ROOM	1,653,588.99	7,555.01
RECOVERY ROOM	302,564.00	1,381.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	194,004.00	1,260.00
OCCUPATIONAL THERAPY	34,453.00	11,844.00
SPEECH PATHOLOGY	7,663.00	4,544.00
RENAL DIALYSIS	0.00	1,353.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,190.00	1,201.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	18,175.00	0.00
OTHER IMAGING SERVICE	615,387.00	33,203.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	76,479.00	35,160.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	57,345.33	2,644.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	23,690.00	521.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,488.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	263,210.00	19,255.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	59,685.00	7,230.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,139,688.83	451,570.93
MRI SERVICES	204,155.00	5,025.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,107,975.00	152,272.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,975,936.39	1,299,000.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,975,936.39	1,299,000.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	384,533.00	ADJUSTMENTS	0.00
COVERED CHARGES	219,044.00	CONTRACTUAL ALLOW	59,732.21
NON-COVERD CHARGES	165,489.00	TOTAL MEDICAID LIAB	159,311.79
		LESS: COB	159,071.43
		LESS: COPAYMENT	240.36
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 145

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,412.00	124,752.00
MED/SURG SUPPLY	24,026.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,930.00	190.00
CT SCAN	23,331.00	6,885.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	968.00	0.00
IV THERAPY	14,780.00	300.00
OPERATING ROOM	31,222.00	19,457.00
LABOR/DELIVERY ROOM	6,312.00	0.00
RESPIRATORY SERVICES	372.00	0.00
ANESTHESIA	6,528.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,483.00	0.00
RECOVERY ROOM	6,905.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,066.00	0.00
OCCUPATIONAL THERAPY	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 SERVICE	4,254.00	8,493.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,500.00	2,344.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	843.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,759.00	396.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,470.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,165.00	2,367.00
MRI SERVICES	1,791.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,777.00	305.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	219,044.00	165,489.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	219,044.00	165,489.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	806,567.40	ADJUSTMENTS	6,996.11
COVERED CHARGES	773,382.80	CONTRACTUAL ALLOW	732,310.18
NON-COVERD CHARGES	33,184.60	TOTAL MEDICAID LIAB	41,072.62
		LESS: COB	0.00
		LESS: COPAYMENT	1,314.11
		REIMBURSEMENT	39,758.51

TOTAL NUMBER OF CLAIMS 734

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,372.00	2,788.00
MED/SURG SUPPLY	1,298.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,181.00	346.00
CT SCAN	28,089.00	1,039.00
PHYSICAL THERAPY	0.00	1,431.00
EKG/ECG	5,566.00	0.00
IV THERAPY	37,484.00	1,050.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,332.00	372.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	412,536.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,212.00	0.00
OCCUPATIONAL THERAPY	0.00	318.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	33,247.00	4,103.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	986.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,870.00	4,059.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,529.00	804.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	116,523.80	10,900.60
MRI SERVICES	12,767.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,390.00	5,974.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	773,382.80	33,184.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	773,382.80	33,184.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,630.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,843.00	CONTRACTUAL ALLOW	18,412.20
NON-COVERD CHARGES	4,787.00	TOTAL MEDICAID LIAB	5,430.80
		LESS: COB	5,391.79
		LESS: COPAYMENT	39.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	504.00	191.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,091.00	0.00
CT SCAN	1,039.00	3,089.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	242.00	0.00
IV THERAPY	891.00	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	13,133.00	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 SERVICE	374.00	922.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,169.00	436.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	400.00	149.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	23,843.00	4,787.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,843.00	4,787.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,247,817.00	ADJUSTMENTS	82,636.35
COVERED CHARGES	2,184,858.64	CONTRACTUAL ALLOW	1,834,932.66
NON-COVERD CHARGES	62,958.36	TOTAL MEDICAID LIAB	349,925.98
		LESS: COB	5,042.00
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	344,415.98

TOTAL NUMBER OF CLAIMS 70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	299,585.00	4,291.00
MED/SURG SUPPLY	245,478.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,133.00	1,511.00
CT SCAN	12,103.00	0.00
PHYSICAL THERAPY	0.00	569.00
EKG/ECG	605.00	121.00
IV THERAPY	64,088.00	75.00
OPERATING ROOM	242,227.64	19,515.36
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	950.00	0.00
ANESTHESIA	63,582.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,890.00	0.00
RECOVERY ROOM	40,218.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	97,818.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	18,175.00	0.00
OTHER IMAGING SERVICE	551.00	1,129.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,997.00	2,930.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,163.00	4,694.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,867.00	189.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,428.00	2,349.00
MRI SERVICES	1,887.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	999,113.00	25,585.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,184,858.64	62,958.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,184,858.64	62,958.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,565.00	ADJUSTMENTS	0.00
COVERED CHARGES	63,185.00	CONTRACTUAL ALLOW	30,597.00
NON-COVERD CHARGES	380.00	TOTAL MEDICAID LIAB	32,588.00
		LESS: COB	32,582.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100.00	250.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	261.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,560.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,264.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	63,185.00	380.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	63,185.00	380.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,815.10	ADJUSTMENTS	4,599.77
COVERED CHARGES	75,815.10	CONTRACTUAL ALLOW	15,389.42
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	60,425.68
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	60,425.68

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	35	0	19,312.00	0.00
ROUTINE NURSERY	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	35	0	19,312.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	35	0	19,312.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,129.80	0.00	OTHER LAB	1,004.99	0.00
MED/SURG SUPPLY	3,437.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,634.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,185.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,074.33	0.00	MRI SERVICES	1,688.09	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,676.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	918.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,579.21	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	56,503.10	0.00
TOTAL ACCOMODATIONS	19,312.00	0.00
TOTAL CHARGES	75,815.10	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	515,788.23	ADJUSTMENTS	8,752.21
COVERED CHARGES	413,147.76	CONTRACTUAL ALLOW	265,562.76
NON-COVERD CHARGES	102,640.47	TOTAL MEDICAID LIAB	147,585.00
		LESS: COB	2,160.65
		LESS: COPAYMENT	1,119.00
		REIMBURSEMENT	144,305.35
		ALL OTHER	115,266.93
		FEE SCHEDULE-LAB	23,704.96
		INJECTABLE DRUGS	5,333.46

TOTAL NUMBER OF CLAIMS 647

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,706.04	470.17	OTHER LAB	2,009.98	465.75
MED/SURG SUPPLY	3,903.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	318.78	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,495.18	1,230.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,085.95	25,634.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	173,732.58	54,243.73
EKG/ECG	5,243.53	2,392.92	MRI SERVICES	18,891.07	6,531.89
IV THERAPY	3,774.43	101.43	PROFESSIONAL FEES	0.00	2,768.63
OPERATING ROOM	4,217.63	2,410.52	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,724.98	1,673.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,591.03	1,375.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,549.19	77.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	5.18
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	9,118.58	1,812.31			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	543.39	129.38			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,290.72	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	743.14	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,391.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,135.73	998.17			

TOTAL ANCILLARY	413,147.76	102,640.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	413,147.76	102,640.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
501	2212072006509	12/19/10 - 12/19/10	03/19/12	0.00	5.18	0.00	2,160.65	0.00
TOTAL				0.00	5.18	0.00	2,160.65	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,127.43	ADJUSTMENTS	141.00
COVERED CHARGES	37,645.63	CONTRACTUAL ALLOW	33,745.63
NON-COVERD CHARGES	3,481.80	TOTAL MEDICAID LIAB	3,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	3,768.00

TOTAL NUMBER OF CLAIMS 78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	566.03	0.00
MED/SURG SUPPLY	85.91	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,313.43	173.88
CT SCAN	2,962.17	1,627.02
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	202.86	0.00
IV THERAPY	227.66	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	256.68	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,775.20	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 SERVICE	408.83	1,130.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	345.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,330.35	550.67
MRI SERVICES	1,956.15	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,215.36	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,645.63	3,481.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,645.63	3,481.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,606.32	ADJUSTMENTS	0.00
COVERED CHARGES	1,606.32	CONTRACTUAL ALLOW	522.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,084.27
		LESS: COB	1,084.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,138.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33.12	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	434.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,606.32	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,606.32	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	108,056.79	ADJUSTMENTS	0.00
COVERED CHARGES	91,591.38	CONTRACTUAL ALLOW	64,993.02
NON-COVERD CHARGES	16,465.41	TOTAL MEDICAID LIAB	26,598.36
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	26,442.36

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,736.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,788.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,338.12	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	238.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,496.66	FEE SCHEDULE LAB	4,247.81	252.55
EKG/ECG	202.86	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,069.43	298.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,307.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	91,591.38	6,385.41
TOTAL ACCOMODATIONS	0.00	10,080.00
TOTAL CHARGES	91,591.38	16,465.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEMORIAL HOSPITAL
PO BOX 188
FOLKSTON,GA 31537-0188

PROVIDER NUMBER
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	53,918,887.81	ADJUSTMENTS	4,016,579.63
COVERED CHARGES	52,788,891.65	CONTRACTUAL ALLOW	37,025,937.54
NON-COVERD CHARGES	1,129,996.16	TOTAL MEDICAID LIAB	15,762,954.11
		LESS: COB	47,705.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,715,248.88

TOTAL NUMBER OF ADMISSIONS 2,290

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,346	3	5,235,712.00	268,092.00
ROUTINE NURSERY	1,770	0	2,337,109.00	187,968.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	7	0.00	0.00
TOTAL ROUTINE	8,116	10	7,572,821.00	456,060.00
SPECIAL CARE SERVICES				
CCU	1,428	0	1,343,168.64	0.00
ICU	1,575	2	3,691,200.00	4,614.00
NICU	490	0	1,359,260.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	15,202.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,493	13	6,393,628.64	19,816.00
TOTAL ACCOMODATIONS	11,609	23	13,966,449.64	475,876.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,652,207.67	64,414.09
MED/SURG SUPPLY	3,456,557.02	25,695.79
LABORATORY-GENERAL	8,992,284.41	67,544.80
RADIOLOGY-DIAGNOSTIC	805,404.51	2,084.44
CT SCAN	1,914,711.69	243,016.16
PHYSICAL THERAPY	197,523.30	14,220.29
EKG/ECG	265,757.27	195.92
IV THERAPY	567,767.53	6,549.35
OPERATING ROOM	1,530,918.76	2,716.21
LABOR/DELIVERY ROOM	1,160,432.08	0.00
RESPIRATORY SERVICES	3,269,217.35	7,532.35
ANESTHESIA	633,871.18	835.73
GI SERVICES	527,063.01	3,572.21
EMERGENCY ROOM	1,781,060.95	7,506.65
RECOVERY ROOM	450,917.84	1,290.69
LABORATORY PATHOLOGIC	285,344.24	432.48
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	73,945.97	4,056.19
SPEECH PATHOLOGY	106,984.39	11,855.40
RENAL DIALYSIS	145,189.64	34,199.01
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	551.81	1,469.65
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	551,349.62	1,088.81
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	727,668.14	6,856.70
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	332,402.75	93,674.65
AUDIOLOGY	536,092.28	1,775.14
CARDIOLOGY	1,855,346.50	0.00
AMBULATORY SURGERY	2,771.38	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	35,422.12	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	367,925.71	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	533,710.78	27,494.89
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	7,318.10	31.46
OTHER THERAPEUTIC SVC	676.53	23,305.42
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	965,853.66	0.00
PROFESSIONAL FEES	0.00	18.51
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	533.60
INJECTABLE DRUGS	88,193.82	153.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	38,822,442.01	654,120.16
TOTAL ACCOMODATIONS	13,966,449.64	475,876.00
TOTAL CHARGES	52,788,891.65	1,129,996.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,843.76	ADJUSTMENTS	0.00
COVERED CHARGES	85,459.04	CONTRACTUAL ALLOW	59,042.58
NON-COVERD CHARGES	2,384.72	TOTAL MEDICAID LIAB	26,416.46
		LESS: COB	26,416.46
		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	15	0	12,180.00	1,233.00
ROUTINE NURSERY	2	0	1,592.00	26.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	0	13,772.00	1,259.00
SPECIAL CARE SERVICES				
CCU	2	0	1,882.00	0.00
ICU	1	0	2,307.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	4,189.00	0.00
TOTAL ACCOMODATIONS	20	0	17,961.00	1,259.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,379.77	0.00
MED/SURG SUPPLY	7,457.83	0.00
LABORATORY-GENERAL	16,623.54	0.00
RADIOLOGY-DIAGNOSTIC	813.93	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	587.76	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,929.13	0.00
LABOR/DELIVERY ROOM	4,567.12	0.00
RESPIRATORY SERVICES	604.96	0.00
ANESTHESIA	1,709.27	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,209.92	0.00
LABORATORY PATHOLOGIC	533.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	2,144.76	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,733.32	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,670.31	1,125.72
AUDIOLOGY	887.57	0.00
CARDIOLOGY	3,386.27	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,550.58	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	708.92	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	67,498.04	1,125.72
TOTAL ACCOMODATIONS	17,961.00	1,259.00
TOTAL CHARGES	85,459.04	2,384.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,171,696.59	ADJUSTMENTS	820,862.12
COVERED CHARGES	19,291,032.04	CONTRACTUAL ALLOW	14,932,088.86
NON-COVERD CHARGES	2,880,664.55	TOTAL MEDICAID LIAB	4,358,943.18
		LESS: COB	7,982.90
		LESS: COPAYMENT	5,951.20
		REIMBURSEMENT	4,345,009.08
		ALL OTHER	3,733,264.62
		FEE SCHEDULE-LAB	379,886.25
		INJECTABLE DRUGS	231,858.21

TOTAL NUMBER OF CLAIMS 9,168

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,929.62	5,188.73
MED/SURG SUPPLY	906,664.71	20,571.51
LABORATORY-GENERAL	0.00	246.82
RADIOLOGY-DIAGNOSTIC	797,465.78	17,110.70
CT SCAN	1,649,113.51	329,899.30
PHYSICAL THERAPY	19,146.17	10,907.39
EKG/ECG	174,696.31	1,132.54
IV THERAPY	779,095.96	19,751.76
OPERATING ROOM	1,071,651.12	273,586.79
LABOR/DELIVERY ROOM	168,717.43	0.00
RESPIRATORY SERVICES	98,653.26	1,854.92
ANESTHESIA	468,952.63	1,904.27
GI SERVICES	372,864.37	54,627.00
EMERGENCY ROOM	4,394,938.05	63,634.48
RECOVERY ROOM	394,884.40	0.00
LABORATORY PATHOLOGIC	0.00	1,529.24
RADIOLOGY THERAPEUTIC	144,973.68	0.00
OCCUPATIONAL THERAPY	6,419.56	7,102.19
SPEECH PATHOLOGY	796.30	3,599.93
RENAL DIALYSIS	0.00	87,046.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	323,397.37	16,414.02
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,407,573.23	175,525.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	84,210.48	15,698.55
ONCOLOGY	16,180.72	0.00
NUCLEAR MEDICINE	165,340.05	99,462.64
AUDIOLOGY	0.00	0.00
CARDIOLOGY	194,961.17	198,758.09
AMBULATORY SURGERY	40,880.99	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,891.88	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	362,478.66	10,324.76

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	233,459.10	812.01
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,072.72	372.52
OTHER THERAPEUTIC SVC	0.00	13,754.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,225,299.79	710,209.79
MRI SERVICES	405,269.63	22,410.39
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	53.50
INJECTABLE DRUGS	1,106,053.39	716,843.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	331.01

TOTAL ANCILLARY	19,291,032.04	2,880,664.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,291,032.04	2,880,664.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2581	4410259086084	07/19/10 - 07/19/10	09/27/10	0.00	85.38	0.00	0.00	0.00
4501	4410259133125	07/22/10 - 07/22/10	09/27/10	0.00	152.92	0.00	0.00	0.00
-1	9711070902008	08/02/10 - 08/02/10	03/21/11	0.00	92.71	0.00	0.00	0.00
TOTAL				0.00	331.01	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,322.07	ADJUSTMENTS	0.00
COVERED CHARGES	68,325.38	CONTRACTUAL ALLOW	4,104.48
NON-COVERD CHARGES	34,996.69	TOTAL MEDICAID LIAB	64,220.90
		LESS: COB	64,203.11
		LESS: COPAYMENT	17.79
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	655.15	0.00
MED/SURG SUPPLY	5,521.28	0.00
LABORATORY-GENERAL	0.00	40.96
RADIOLOGY-DIAGNOSTIC	1,298.28	0.00
CT SCAN	2,772.73	4,618.49
PHYSICAL THERAPY	0.00	424.77
EKG/ECG	415.35	0.00
IV THERAPY	2,775.51	0.00
OPERATING ROOM	7,167.93	1.00
LABOR/DELIVERY ROOM	2,108.64	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,802.15	0.00
GI SERVICES	0.00	3,177.43
EMERGENCY ROOM	13,992.06	153.54
RECOVERY ROOM	2,735.17	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	387.78	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	729.34	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,783.87	18,528.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,819.56	5,916.38
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	463.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,223.64	1,746.33
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	673.44	389.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	68,325.38	34,996.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,325.38	34,996.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,645,291.32	ADJUSTMENTS	10,792.63
COVERED CHARGES	1,544,224.66	CONTRACTUAL ALLOW	1,463,304.90
NON-COVERD CHARGES	101,066.66	TOTAL MEDICAID LIAB	80,919.76
		LESS: COB	0.00
		LESS: COPAYMENT	2,391.15
		REIMBURSEMENT	78,528.61
		TOTAL NUMBER OF CLAIMS	1,445

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,438.67	179.69
MED/SURG SUPPLY	24,643.88	0.00
LABORATORY-GENERAL	0.00	75.16
RADIOLOGY-DIAGNOSTIC	69,785.06	1,244.27
CT SCAN	90,026.90	11,363.93
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	19,492.09	0.00
IV THERAPY	45,650.81	0.00
OPERATING ROOM	8,986.79	6,120.78
LABOR/DELIVERY ROOM	952.81	0.00
RESPIRATORY SERVICES	4,098.97	0.00
ANESTHESIA	2,761.19	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	855,926.94	2,317.02
RECOVERY ROOM	2,063.95	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,252.92	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	729.34	304.42
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	78,041.03	16,469.56
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	2,409.01	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,950.94	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,802.77	161.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	274,750.07	55,082.75
MRI SERVICES	3,730.97	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,729.55	7,747.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,544,224.66	101,066.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,544,224.66	101,066.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,705.55	ADJUSTMENTS	0.00
COVERED CHARGES	10,965.19	CONTRACTUAL ALLOW	8,229.43
NON-COVERD CHARGES	1,740.36	TOTAL MEDICAID LIAB	2,735.76
		LESS: COB	2,729.76
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.13	0.00
MED/SURG SUPPLY	450.96	47.66
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	264.74	0.00
CT SCAN	2,027.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,976.55	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	3,843.58	460.62
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,144.47	1,169.24
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	210.26	62.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,965.19	1,740.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,965.19	1,740.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,044,790.56	ADJUSTMENTS	84,758.16
COVERED CHARGES	2,634,539.86	CONTRACTUAL ALLOW	2,193,873.60
NON-COVERD CHARGES	410,250.70	TOTAL MEDICAID LIAB	440,666.26
		LESS: COB	0.00
		LESS: COPAYMENT	714.00
		REIMBURSEMENT	439,952.26

TOTAL NUMBER OF CLAIMS 89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,664.05	499.17
MED/SURG SUPPLY	484,730.33	1,643.59
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,556.36	1,486.96
CT SCAN	10,536.27	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,139.63	0.00
IV THERAPY	48,564.01	0.00
OPERATING ROOM	253,528.43	6,122.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	463.14	0.00
ANESTHESIA	72,148.33	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,555.62	0.00
RECOVERY ROOM	38,349.65	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	73,907.80	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	28,729.49	3,400.02
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	35,522.76	0.00
OTHER IMAGING SERVICE	14,859.22	3,587.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	3,909.01	0.00
NUCLEAR MEDICINE	542.51	276.71
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	76,671.39
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,125.66	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	766.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,375.25	7,132.58
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	21.85
INJECTABLE DRUGS	1,439,332.34	308,642.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,634,539.86	410,250.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,634,539.86	410,250.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	204,243.41	ADJUSTMENTS	0.00
COVERED CHARGES	204,243.41	CONTRACTUAL ALLOW	106,183.69
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	98,059.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	98,059.72

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	75	0	21,900.00	0.00
ROUTINE NURSERY	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	21,900.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	75	0	21,900.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,434.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23,374.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,159.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,468.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,508.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	669.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,369.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,132.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,836.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	310.00	0.00			

TOTAL ANCILLARY	182,343.41	0.00
TOTAL ACCOMODATIONS	21,900.00	0.00
TOTAL CHARGES	204,243.41	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	709,079.94	ADJUSTMENTS	19,854.65
COVERED CHARGES	644,118.13	CONTRACTUAL ALLOW	264,560.11
NON-COVERD CHARGES	64,961.81	TOTAL MEDICAID LIAB	379,558.02
		LESS: COB	1,124.03
		LESS: COPAYMENT	1,782.00
		REIMBURSEMENT	376,651.99
		ALL OTHER	350,944.75
		FEE SCHEDULE-LAB	25,707.24
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,055

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,819.98	52.22
MED/SURG SUPPLY	27,557.22	242.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,145.00	281.00
CT SCAN	95,310.00	2,395.22
PHYSICAL THERAPY	184.00	1,698.00
EKG/ECG	16,352.00	1,380.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,976.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,462.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	68,069.00	913.00
RECOVERY ROOM	1,344.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	374.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,535.00	423.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	37.87
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,079.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	72,640.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,765.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,552.00	626.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	201,287.93	56,137.00
MRI SERVICES	13,867.00	0.00
PROFESSIONAL FEES	0.00	723.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	12,799.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	53.00

TOTAL ANCILLARY	644,118.13	64,961.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	644,118.13	64,961.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	5910328000246	11/10/10 - 11/10/10	11/29/10	0.00	53.00	0.00	0.00	0.00
TOTAL				0.00	53.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,487.10	ADJUSTMENTS	108.88
COVERED CHARGES	15,131.10	CONTRACTUAL ALLOW	11,361.88
NON-COVERD CHARGES	356.00	TOTAL MEDICAID LIAB	3,769.22
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	3,643.22

TOTAL NUMBER OF CLAIMS 68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,244.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	384.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	322.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,518.40	356.00
EKG/ECG	162.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115.00	0.00	FREE STANDING CLINIC	74.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,311.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,131.10	356.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,131.10	356.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,092.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,077.00	CONTRACTUAL ALLOW	949.90
NON-COVERD CHARGES	15.00	TOTAL MEDICAID LIAB	2,127.10
		LESS: COB	2,127.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,353.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	279.00	15.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,077.00	15.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,077.00	15.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,539.77	ADJUSTMENTS	0.00
COVERED CHARGES	33,506.36	CONTRACTUAL ALLOW	10,816.56
NON-COVERD CHARGES	3,033.41	TOTAL MEDICAID LIAB	22,689.80
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	22,683.80

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,643.32	0.00
MED/SURG SUPPLY	1,701.04	46.41
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	843.00	0.00
CT SCAN	14,324.00	1,484.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,354.00	162.00
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	4,958.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	720.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,637.00	1,341.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,506.36	3,033.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,506.36	3,033.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,672,455.60	ADJUSTMENTS	6,019,681.56
COVERED CHARGES	60,005,921.87	CONTRACTUAL ALLOW	42,510,180.65
NON-COVERD CHARGES	3,666,533.73	TOTAL MEDICAID LIAB	17,495,741.22
		LESS: COB	109,952.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,385,789.05

TOTAL NUMBER OF ADMISSIONS 2,753

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,956	46	6,490,980.00	2,728,047.00
ROUTINE NURSERY	1,235	0	469,522.00	45,472.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	10	0.00	0.00
TOTAL ROUTINE	8,191	56	6,960,502.00	2,773,519.00
SPECIAL CARE SERVICES				
CCU	2,412	0	3,434,276.00	2,804.00
ICU	1,186	0	2,550,248.00	0.00
NICU	970	0	2,279,015.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	155	0.00	208,320.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,568	155	8,263,539.00	211,124.00
TOTAL ACCOMODATIONS	12,759	211	15,224,041.00	2,984,643.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,359,178.60	34,391.50
MED/SURG SUPPLY	3,057,729.35	26,358.00
LABORATORY-GENERAL	8,059,651.00	11,400.00
RADIOLOGY-DIAGNOSTIC	1,201,383.00	0.00
CT SCAN	2,410,182.00	1,436.00
PHYSICAL THERAPY	271,038.00	2,253.00
EKG/ECG	296,940.00	207.00
IV THERAPY	224,419.00	32,396.00
OPERATING ROOM	3,086,328.00	2,769.00
LABOR/DELIVERY ROOM	3,128,451.44	58,386.00
RESPIRATORY SERVICES	3,847,518.00	5,078.00
ANESTHESIA	586,915.00	1,573.00
GI SERVICES	13,872.00	0.00
EMERGENCY ROOM	2,278,908.00	16,110.00
RECOVERY ROOM	649,281.00	0.00
LABORATORY PATHOLOGIC	198,939.00	1,071.00
RADIOLOGY THERAPEUTIC	40,139.00	0.00
OCCUPATIONAL THERAPY	136,894.00	4,633.00
SPEECH PATHOLOGY	110,017.00	900.00
RENAL DIALYSIS	1,172,523.00	295,096.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,719.00	4,099.00
PSYCHIATRIC SERVICES	24,133.00	5,372.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	396,480.00	7,548.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	614,312.00	97,684.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	565,675.00	24,990.00
AUDIOLOGY	304,619.00	0.00
CARDIOLOGY	2,125,881.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166,893.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	93,006.83	3,048.23

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	405,940.00	0.00
RECREATIONAL THERAPY	250.00	0.00
EDUCATION & TRAINING	50,894.00	0.00
OTHER THERAPEUTIC SVC	0.00	24,065.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	883,376.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,395.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	21,027.00

TOTAL ANCILLARY	44,781,880.87	681,890.73
TOTAL ACCOMODATIONS	15,224,041.00	2,984,643.00
TOTAL CHARGES	60,005,921.87	3,666,533.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
242	4410259010567	07/12/10 - 07/12/10	09/27/10	0.00	392.00	0.00	0.00	0.00
2581	4410259035989	07/11/10 - 07/11/10	09/27/10	0.00	450.00	0.00	0.00	0.00
3006	4410259035989	07/11/10 - 07/11/10	09/27/10	0.00	248.00	0.00	0.00	0.00
3600	4410259035989	07/11/10 - 07/11/10	09/27/10	0.00	4,484.00	0.00	0.00	0.00
2581	4410259111562	07/12/10 - 07/12/10	09/27/10	0.00	450.00	0.00	0.00	0.00
3001	4410259111562	07/12/10 - 07/12/10	09/27/10	0.00	103.00	0.00	0.00	0.00
3006	4010263062270	08/16/10 - 08/16/10	10/04/10	0.00	112.00	0.00	0.00	0.00
3006	4410293000004	07/14/10 - 07/14/10	10/25/10	0.00	248.00	0.00	0.00	0.00
2725	4410293000005	07/06/10 - 07/06/10	10/25/10	0.00	465.00	0.00	0.00	0.00
3600	4410293000005	07/06/10 - 07/06/10	10/25/10	0.00	4,840.00	0.00	0.00	0.00
2728	2310315000043	08/09/10 - 08/09/10	11/15/10	0.00	410.00	0.00	0.00	0.00
3600	2310315000043	08/09/10 - 08/09/10	11/15/10	0.00	5,810.00	0.00	0.00	0.00
615	1111131000430	01/16/11 - 01/20/11	06/13/11	0.00	2,699.00	0.00	0.00	0.00
3012	2211326008841	05/03/11 - 05/10/11	11/28/11	0.00	316.00	0.00	0.00	0.00
TOTAL				0.00	21,027.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	741,009.10	ADJUSTMENTS	0.00
COVERED CHARGES	623,040.60	CONTRACTUAL ALLOW	156,630.27
NON-COVERD CHARGES	117,968.50	TOTAL MEDICAID LIAB	466,410.33
		LESS: COB	466,410.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	51	0	44,928.00	18,702.00
ROUTINE NURSERY	37	0	17,748.00	6,372.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	88	0	62,676.00	25,074.00
SPECIAL CARE SERVICES				
CCU	4	0	5,768.00	0.00
ICU	2	0	2,804.00	0.00
NICU	75	0	184,802.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	25	0.00	33,600.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	81	25	193,374.00	33,600.00
TOTAL ACCOMODATIONS	169	25	256,050.00	58,674.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,325.10	11,887.50
MED/SURG SUPPLY	41,382.00	3,473.00
LABORATORY-GENERAL	61,659.00	354.00
RADIOLOGY-DIAGNOSTIC	7,961.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	10,492.00	0.00
EKG/ECG	621.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	22,504.00	0.00
LABOR/DELIVERY ROOM	27,194.00	31,626.00
RESPIRATORY SERVICES	38,004.00	0.00
ANESTHESIA	0.00	1,224.00
GI SERVICES	1,700.00	0.00
EMERGENCY ROOM	4,533.00	0.00
RECOVERY ROOM	6,337.00	0.00
LABORATORY PATHOLOGIC	519.00	336.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,835.00	0.00
SPEECH PATHOLOGY	9,364.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	347.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,901.00	474.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,740.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	5,158.00	0.00
CARDIOLOGY	5,917.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	921.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	7,446.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,455.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,307.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,447.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	367.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,474.00

TOTAL ANCILLARY	366,990.60	59,294.50
TOTAL ACCOMODATIONS	256,050.00	58,674.00
TOTAL CHARGES	623,040.60	117,968.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
325	2211125013427	10/05/10 - 10/15/10	05/09/11	0.00	2,474.00	0.00	5,887.08	0.00
TOTAL				0.00	2,474.00	0.00	5,887.08	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,066,614.34	ADJUSTMENTS	1,325,036.17
COVERED CHARGES	19,889,426.26	CONTRACTUAL ALLOW	15,907,650.14
NON-COVERD CHARGES	2,177,188.08	TOTAL MEDICAID LIAB	3,981,776.12
		LESS: COB	5,897.09
		LESS: COPAYMENT	7,938.37
		REIMBURSEMENT	3,967,940.66
		ALL OTHER	3,586,755.87
		FEE SCHEDULE-LAB	277,390.90
		INJECTABLE DRUGS	103,793.89

TOTAL NUMBER OF CLAIMS 9,030

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822,940.83	3,325.25
MED/SURG SUPPLY	745,036.24	17,386.00
LABORATORY-GENERAL	0.00	3,186.00
RADIOLOGY-DIAGNOSTIC	1,077,369.00	34,968.00
CT SCAN	2,204,858.00	598,044.00
PHYSICAL THERAPY	53,772.00	31,666.00
EKG/ECG	234,694.00	0.00
IV THERAPY	121,879.00	1,066.00
OPERATING ROOM	1,356,691.00	376,876.00
LABOR/DELIVERY ROOM	346,640.00	3,325.00
RESPIRATORY SERVICES	185,735.00	31,882.00
ANESTHESIA	619,697.00	7,768.00
GI SERVICES	8,367.00	0.00
EMERGENCY ROOM	4,970,712.00	50,585.00
RECOVERY ROOM	620,523.00	4,210.00
LABORATORY PATHOLOGIC	0.00	599.00
RADIOLOGY THERAPEUTIC	73,526.00	486.00
OCCUPATIONAL THERAPY	17,575.00	5,557.00
SPEECH PATHOLOGY	8,294.00	3,021.00
RENAL DIALYSIS	0.00	18,308.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	157,250.00	8,012.00
PSYCHIATRIC SERVICES	183.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	584,195.00	31,344.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	56,035.00	6,464.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	491,772.00	3,996.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	488,419.00	169,429.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,093.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	417,028.42	5,570.05

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	149,422.00	7,792.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	111.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,257,194.02	450,300.03
MRI SERVICES	280,564.00	72,991.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	532,850.75	227,787.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	323.00

TOTAL ANCILLARY	19,889,426.26	2,176,267.08
TOTAL ACCOMODATIONS	0.00	921.00
TOTAL CHARGES	19,889,426.26	2,177,188.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3050	4010253056354	07/20/10 - 07/20/10	09/27/10	0.00	120.00	0.00	0.00	0.00
3060	4010253056354	07/20/10 - 07/20/10	09/27/10	0.00	203.00	0.00	0.00	0.00
TOTAL				0.00	323.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	266,824.82	ADJUSTMENTS	0.00
COVERED CHARGES	229,882.58	CONTRACTUAL ALLOW	89,589.93
NON-COVERD CHARGES	36,942.24	TOTAL MEDICAID LIAB	140,292.65
		LESS: COB	140,218.03
		LESS: COPAYMENT	74.62
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	129

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,818.50	49.50
MED/SURG SUPPLY	8,063.00	8,844.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,704.00	541.00
CT SCAN	8,169.00	2,000.00
PHYSICAL THERAPY	249.00	0.00
EKG/ECG	2,552.00	0.00
IV THERAPY	2,283.00	0.00
OPERATING ROOM	20,790.00	6,661.00
LABOR/DELIVERY ROOM	23,158.00	0.00
RESPIRATORY SERVICES	1,350.00	509.00
ANESTHESIA	9,893.00	1,224.00
GI SERVICES	1,651.00	0.00
EMERGENCY ROOM	50,890.00	834.00
RECOVERY ROOM	11,690.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,225.00	1,602.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,449.00	4,866.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	813.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,853.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,119.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,118.28	3,692.74
MRI SERVICES	0.00	4,881.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,044.00	1,238.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	229,882.58	36,942.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,882.58	36,942.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,797,362.03	ADJUSTMENTS	13,319.42
COVERED CHARGES	1,714,206.53	CONTRACTUAL ALLOW	1,631,295.64
NON-COVERD CHARGES	83,155.50	TOTAL MEDICAID LIAB	82,910.89
		LESS: COB	676.31
		LESS: COPAYMENT	2,286.00
		REIMBURSEMENT	79,948.58

TOTAL NUMBER OF CLAIMS 1,476

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,914.25	0.00
MED/SURG SUPPLY	8,708.00	7.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,434.00	2,294.00
CT SCAN	74,254.00	34,453.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	20,264.00	0.00
IV THERAPY	3,782.00	0.00
OPERATING ROOM	2,068.00	0.00
LABOR/DELIVERY ROOM	1,348.00	0.00
RESPIRATORY SERVICES	11,335.00	471.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,009,226.00	6,035.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	3,892.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	323.00	60.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,571.00	5,408.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,768.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,802.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	362,239.00	29,195.00
MRI SERVICES	21,170.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,340.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,714,206.53	83,155.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,714,206.53	83,155.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,944.25	ADJUSTMENTS	0.00
COVERED CHARGES	33,851.25	CONTRACTUAL ALLOW	23,323.29
NON-COVERD CHARGES	3,093.00	TOTAL MEDICAID LIAB	10,527.96
		LESS: COB	10,506.96
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	690.25	0.00	OTHER LAB	895.00	829.00
MED/SURG SUPPLY	213.00	7.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,499.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,474.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,481.00	1,320.00
EKG/ECG	655.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	91.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,435.00	322.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,505.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	176.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	913.00	439.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	33,851.25	3,093.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,851.25	3,093.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3018	4010264043143	07/09/10 - 07/09/10	09/27/10	0.00	176.00	0.00	1,609.00	0.00
TOTAL				0.00	176.00	0.00	1,609.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,970,339.77	ADJUSTMENTS	104,323.46
COVERED CHARGES	1,885,716.77	CONTRACTUAL ALLOW	1,621,903.43
NON-COVERD CHARGES	84,623.00	TOTAL MEDICAID LIAB	263,813.34
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	263,444.34

TOTAL NUMBER OF CLAIMS 53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,252.25	0.00
MED/SURG SUPPLY	299,538.24	21.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,087.00	16,607.00
CT SCAN	14,313.00	0.00
PHYSICAL THERAPY	0.00	249.00
EKG/ECG	1,551.00	0.00
IV THERAPY	25,540.00	0.00
OPERATING ROOM	217,042.00	27,399.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	894.00	0.00
ANESTHESIA	99,646.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,289.00	0.00
RECOVERY ROOM	29,881.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	45,396.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	11,388.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,592.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,064.00	1,217.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,092.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	56,576.00	14,289.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,287.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	18,756.88	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,580.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,765.00	3,423.00
MRI SERVICES	0.00	3,447.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	922,574.40	6,583.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,885,716.77	84,623.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,885,716.77	84,623.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR COBB HOSPITAL
PO BOX 406152
ATLANTA,GA 30384-6152

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,007,273.78	ADJUSTMENTS	19,933.69
COVERED CHARGES	1,007,063.78	CONTRACTUAL ALLOW	375,014.42
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	632,049.36
		LESS: COB	9,607.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	622,441.57

TOTAL NUMBER OF ADMISSIONS 155

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	297	0	113,751.00	210.00
ROUTINE NURSERY	101	0	19,188.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	398	0	132,939.00	210.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	22	0	20,127.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	22	0	20,127.00	0.00
TOTAL ACCOMODATIONS	420	0	153,066.00	210.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,308.90	0.00
MED/SURG SUPPLY	83,511.64	0.00
LABORATORY-GENERAL	186,557.00	0.00
RADIOLOGY-DIAGNOSTIC	11,469.00	0.00
CT SCAN	44,706.00	0.00
PHYSICAL THERAPY	9,381.00	0.00
EKG/ECG	8,265.00	0.00
IV THERAPY	4,633.00	0.00
OPERATING ROOM	20,636.00	0.00
LABOR/DELIVERY ROOM	124,255.00	0.00
RESPIRATORY SERVICES	39,788.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,746.00	0.00
EMERGENCY ROOM	43,256.74	0.00
RECOVERY ROOM	5,734.00	0.00
LABORATORY PATHOLOGIC	377.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	266.00	0.00
SPEECH PATHOLOGY	2,020.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,834.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,533.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,082.00	0.00
AUDIOLOGY	1,722.00	0.00
CARDIOLOGY	10,430.00	0.00
AMBULATORY SURGERY	3,990.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	794.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,533.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,158.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,366.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	146,645.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	853,997.78	0.00
TOTAL ACCOMODATIONS	153,066.00	210.00
TOTAL CHARGES	1,007,063.78	210.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,721.50	ADJUSTMENTS	0.00
COVERED CHARGES	12,721.50	CONTRACTUAL ALLOW	3,287.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,433.73
		LESS: COB	9,433.73
		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	6	0	2,298.00	0.00
ROUTINE NURSERY	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	2,298.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,298.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	995.00	0.00
MED/SURG SUPPLY	304.00	0.00
LABORATORY-GENERAL	3,512.00	0.00
RADIOLOGY-DIAGNOSTIC	327.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	290.00	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	412.00	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	475.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	532.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,043.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	160.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,373.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,423.50	0.00
TOTAL ACCOMODATIONS	2,298.00	0.00
TOTAL CHARGES	12,721.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,652,651.57	ADJUSTMENTS	105,705.15
COVERED CHARGES	1,560,536.83	CONTRACTUAL ALLOW	1,132,093.78
NON-COVERD CHARGES	92,114.74	TOTAL MEDICAID LIAB	428,443.05
		LESS: COB	842.09
		LESS: COPAYMENT	1,410.00
		REIMBURSEMENT	426,190.96
		ALL OTHER	367,999.12
		FEE SCHEDULE-LAB	48,489.48
		INJECTABLE DRUGS	9,702.36

TOTAL NUMBER OF CLAIMS 1,632

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,360.00	421.00
MED/SURG SUPPLY	59,820.08	172.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,062.00	826.00
CT SCAN	247,251.00	1,013.00
PHYSICAL THERAPY	2,215.00	2,301.00
EKG/ECG	17,443.00	0.00
IV THERAPY	92,893.00	3,639.00
OPERATING ROOM	33,728.00	8,248.00
LABOR/DELIVERY ROOM	2,836.00	0.00
RESPIRATORY SERVICES	6,671.00	3,252.00
ANESTHESIA	0.00	85.00
GI SERVICES	2,658.00	0.00
EMERGENCY ROOM	374,972.15	620.00
RECOVERY ROOM	6,692.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,113.00	0.00
SPEECH PATHOLOGY	0.00	665.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	136.74
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	52,352.00	2,449.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,431.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,507.00	0.00
AUDIOLOGY	41.00	41.00
CARDIOLOGY	8,344.00	0.00
AMBULATORY SURGERY	2,660.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,782.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	36,643.00	375.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,062.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	345,257.40	61,440.00
MRI SERVICES	64,129.00	0.00
PROFESSIONAL FEES	0.00	275.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	73,614.20	6,156.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,560,536.83	92,114.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,560,536.83	92,114.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,224.37	ADJUSTMENTS	0.00
COVERED CHARGES	18,002.37	CONTRACTUAL ALLOW	2,383.85
NON-COVERD CHARGES	4,222.00	TOTAL MEDICAID LIAB	15,618.52
		LESS: COB	15,597.52
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173.00	23.00
MED/SURG SUPPLY	291.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,297.00	0.00
CT SCAN	3,797.00	1,013.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	145.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	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	4,442.37	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	346.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	826.00	346.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	152.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	411.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,997.00	1,888.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	782.00	195.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,002.37	4,222.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,002.37	4,222.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	127,355.51	ADJUSTMENTS	703.22
COVERED CHARGES	119,604.14	CONTRACTUAL ALLOW	106,737.94
NON-COVERD CHARGES	7,751.37	TOTAL MEDICAID LIAB	12,866.20
		LESS: COB	52.00
		LESS: COPAYMENT	525.01
		REIMBURSEMENT	12,289.19

TOTAL NUMBER OF CLAIMS 230

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	890.00	0.00
MED/SURG SUPPLY	1,118.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,350.00	0.00
CT SCAN	5,239.00	0.00
PHYSICAL THERAPY	0.00	300.00
EKG/ECG	435.00	0.00
IV THERAPY	2,438.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	300.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	63,165.14	68.37
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,235.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,043.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	397.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,117.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,149.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,809.00	7,323.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,919.00	60.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	119,604.14	7,751.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,604.14	7,751.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	395.00	ADJUSTMENTS	0.00
COVERED CHARGES	290.00	CONTRACTUAL ALLOW	95.00
NON-COVERD CHARGES	105.00	TOTAL MEDICAID LIAB	195.00
		LESS: COB	195.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	52.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	105.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	290.00	105.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	290.00	105.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,358.50	ADJUSTMENTS	4,967.71
COVERED CHARGES	17,471.50	CONTRACTUAL ALLOW	12,503.79
NON-COVERD CHARGES	887.00	TOTAL MEDICAID LIAB	4,967.71
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,967.71

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	501.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,190.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,161.00	483.00
EKG/ECG	145.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,438.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	404.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,018.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,757.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	353.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	512.00	0.00			

TOTAL ANCILLARY	17,471.50	887.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,471.50	887.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSPITAL
PO BOX 269
ROYSTON,GA 30662-0269

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,146,629.02	ADJUSTMENTS	221,551.01
COVERED CHARGES	8,889,556.02	CONTRACTUAL ALLOW	5,150,792.93
NON-COVERD CHARGES	257,073.00	TOTAL MEDICAID LIAB	3,738,763.09
		LESS: COB	65,392.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,673,370.72

TOTAL NUMBER OF ADMISSIONS 593

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,138	0	1,222,278.00	50,513.00
ROUTINE NURSERY	86	0	42,234.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	3,606.00
TOTAL ROUTINE	2,224	0	1,264,512.00	54,119.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	288	0	302,886.00	0.00
NICU	1	0	601.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	289	0	303,487.00	0.00
TOTAL ACCOMODATIONS	2,513	0	1,567,999.00	54,119.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,541,808.79	0.00
MED/SURG SUPPLY	422,628.93	4,429.00
LABORATORY-GENERAL	1,892,207.56	2,316.00
RADIOLOGY-DIAGNOSTIC	202,622.23	0.00
CT SCAN	423,558.00	51,520.00
PHYSICAL THERAPY	22,640.07	0.00
EKG/ECG	273,847.86	0.00
IV THERAPY	156,303.00	0.00
OPERATING ROOM	466,260.00	0.00
LABOR/DELIVERY ROOM	58,950.00	0.00
RESPIRATORY SERVICES	646,216.00	2,462.00
ANESTHESIA	48,008.00	0.00
GI SERVICES	130,162.00	0.00
EMERGENCY ROOM	226,180.00	0.00
RECOVERY ROOM	21,504.00	0.00
LABORATORY PATHOLOGIC	20,118.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	363.45	0.00
SPEECH PATHOLOGY	2,415.50	0.00
RENAL DIALYSIS	102,147.69	27,213.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	288.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	45,262.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	91,796.47	1,604.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	151,707.00	21,655.00
AUDIOLOGY	2,881.00	0.00
CARDIOLOGY	139,649.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,525.49	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,848.43	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	37,809.42	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	134,187.60	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	77,385.00
INJECTABLE DRUGS	33,661.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	14,370.00

TOTAL ANCILLARY	7,321,557.02	202,954.00
TOTAL ACCOMODATIONS	1,567,999.00	54,119.00
TOTAL CHARGES	8,889,556.02	257,073.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011313044601	10/15/11 - 10/18/11	11/14/11	0.00	2,395.00	0.00	0.00	0.00
615	2011316000175	11/02/11 - 11/04/11	11/21/11	0.00	2,395.00	0.00	0.00	0.00
615	5911325001228	09/12/11 - 09/16/11	11/28/11	0.00	2,395.00	0.00	0.00	0.00
615	2011363066992	12/12/11 - 12/15/11	01/02/12	0.00	2,395.00	0.00	0.00	0.00
181	2212004005063	11/17/11 - 12/08/11	01/09/12	0.00	0.00	0.00	0.00	0.00
615	5212159000097	12/20/11 - 01/26/12	06/11/12	0.00	2,395.00	0.00	0.00	0.00
615	2012202039287	08/18/11 - 08/24/11	07/30/12	0.00	2,395.00	0.00	0.00	0.00
TOTAL				0.00	14,370.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,461.50	ADJUSTMENTS	0.00
COVERED CHARGES	51,579.50	CONTRACTUAL ALLOW	16,453.61
NON-COVERD CHARGES	882.00	TOTAL MEDICAID LIAB	35,125.89
		LESS: COB	35,125.89
		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	15	0	8,635.00	882.00
ROUTINE NURSERY	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	15	0	8,635.00	882.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	8,635.00	882.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,432.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,176.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,166.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	365.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	408.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,573.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,275.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,086.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	861.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	446.00	0.00	INJECTABLE DRUGS	1,020.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,642.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	868.50	0.00			

TOTAL ANCILLARY	42,944.50	0.00
TOTAL ACCOMODATIONS	8,635.00	882.00
TOTAL CHARGES	51,579.50	882.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,892,624.68	ADJUSTMENTS	274,991.07
COVERED CHARGES	6,182,730.64	CONTRACTUAL ALLOW	4,841,759.65
NON-COVERD CHARGES	709,894.04	TOTAL MEDICAID LIAB	1,340,970.99
		LESS: COB	6,898.94
		LESS: COPAYMENT	4,984.33
		REIMBURSEMENT	1,329,087.72
		ALL OTHER	1,160,829.70
		FEE SCHEDULE-LAB	145,520.52
		INJECTABLE DRUGS	22,737.50

TOTAL NUMBER OF CLAIMS 4,563

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,341.00	2,385.00
MED/SURG SUPPLY	356,937.00	44,587.00
LABORATORY-GENERAL	0.00	3,297.00
RADIOLOGY-DIAGNOSTIC	313,819.00	32,372.00
CT SCAN	608,412.00	206,705.00
PHYSICAL THERAPY	37,086.00	2,436.00
EKG/ECG	96,418.00	365.00
IV THERAPY	282,503.00	2,281.00
OPERATING ROOM	588,254.66	197,533.34
LABOR/DELIVERY ROOM	26,382.00	0.00
RESPIRATORY SERVICES	60,135.00	17,751.00
ANESTHESIA	100,701.00	2,348.00
GI SERVICES	63,188.00	12,230.00
EMERGENCY ROOM	848,113.00	2,733.00
RECOVERY ROOM	48,589.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	624.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	18,978.00	3,925.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	169,452.00	10,619.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,704.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	237,263.00	13,362.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	74,662.00	1,782.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	101,182.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	126,218.68	5,596.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,934.00	3,911.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,368,028.30	80,500.70
MRI SERVICES	150,609.00	20,749.00
PROFESSIONAL FEES	0.00	939.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	108.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	147,713.00	39,661.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,182,730.64	708,692.04
TOTAL ACCOMODATIONS	0.00	1,202.00
TOTAL CHARGES	6,182,730.64	709,894.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	146,486.88	ADJUSTMENTS	0.00
COVERED CHARGES	130,000.24	CONTRACTUAL ALLOW	58,490.52
NON-COVERD CHARGES	16,486.64	TOTAL MEDICAID LIAB	71,509.72
		LESS: COB	71,428.72
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 112

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,110.00	0.00
MED/SURG SUPPLY	6,841.00	80.00
LABORATORY-GENERAL	0.00	22.00
RADIOLOGY-DIAGNOSTIC	4,288.00	0.00
CT SCAN	13,836.00	3,594.00
PHYSICAL THERAPY	411.00	370.00
EKG/ECG	1,580.00	0.00
IV THERAPY	3,186.00	0.00
OPERATING ROOM	17,123.00	0.00
LABOR/DELIVERY ROOM	2,626.00	0.00
RESPIRATORY SERVICES	1,829.00	810.00
ANESTHESIA	2,331.00	0.00
GI SERVICES	2,446.00	0.00
EMERGENCY ROOM	16,999.00	0.00
RECOVERY ROOM	307.00	0.00
LABORATORY PATHOLOGIC	0.00	160.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,863.00	2,749.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,544.00	652.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	594.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,004.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,375.24	23.64

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,305.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,625.00	4,528.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	1,179.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	777.00	2,319.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	130,000.24	16,486.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	130,000.24	16,486.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	501,474.93	ADJUSTMENTS	964.92
COVERED CHARGES	473,384.93	CONTRACTUAL ALLOW	432,601.17
NON-COVERD CHARGES	28,090.00	TOTAL MEDICAID LIAB	40,783.76
		LESS: COB	123.51
		LESS: COPAYMENT	1,167.02
		REIMBURSEMENT	39,493.23

TOTAL NUMBER OF CLAIMS 727

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,585.00	73.00
MED/SURG SUPPLY	3,895.00	0.00
LABORATORY-GENERAL	0.00	164.00
RADIOLOGY-DIAGNOSTIC	28,145.00	291.00
CT SCAN	13,126.00	17,522.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,898.00	0.00
IV THERAPY	40,572.00	136.00
OPERATING ROOM	0.00	2,510.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,825.00	1,178.00
ANESTHESIA	351.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	212,772.00	0.00
RECOVERY ROOM	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 SERVICE	8,605.00	494.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,416.93	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,476.00	1,479.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	116,813.00	4,004.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,505.00	239.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	473,384.93	28,090.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	473,384.93	28,090.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,234.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,951.00	CONTRACTUAL ALLOW	10,174.90
NON-COVERD CHARGES	2,283.00	TOTAL MEDICAID LIAB	6,776.10
		LESS: COB	6,764.10
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,279.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	148.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	352.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	779.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,023.00	1,348.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,314.00	141.00
EKG/ECG	158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,882.00	0.00	PROFESSIONAL FEES	0.00	132.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	242.00	310.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,148.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	270.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	708.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,951.00	2,283.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,951.00	2,283.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,930.61	ADJUSTMENTS	0.00
COVERED CHARGES	63,593.27	CONTRACTUAL ALLOW	48,500.34
NON-COVERD CHARGES	24,337.34	TOTAL MEDICAID LIAB	15,092.93
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	15,083.93

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,274.00	0.00
MED/SURG SUPPLY	38,254.00	13,986.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,738.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	158.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,949.66	8,552.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	242.00	0.00
ANESTHESIA	4,989.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	952.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	553.61	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	113.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	108.00	61.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	63,593.27	24,337.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	63,593.27	24,337.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
PO BOX 1287
DOUGLAS,GA 31534-1287

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,796,154.33	ADJUSTMENTS	1,878,475.09
COVERED CHARGES	31,069,580.83	CONTRACTUAL ALLOW	22,362,633.56
NON-COVERD CHARGES	726,573.50	TOTAL MEDICAID LIAB	8,706,947.27
		LESS: COB	88,140.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,618,806.39

TOTAL NUMBER OF ADMISSIONS 905

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,121	6	1,590,438.00	294,816.00
ROUTINE NURSERY	225	0	336,660.00	9,396.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	2,346	10	1,927,098.00	304,212.00
SPECIAL CARE SERVICES				
CCU	1,247	12	1,594,362.00	13,248.00
ICU	1,056	3	2,183,369.00	3,927.00
NICU	97	0	321,532.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	49	0.00	47,432.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,400	64	4,099,263.00	64,607.00
TOTAL ACCOMODATIONS	4,746	74	6,026,361.00	368,819.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,540,977.88	140.00
MED/SURG SUPPLY	1,839,965.41	3,761.25
LABORATORY-GENERAL	4,752,028.75	1,726.00
RADIOLOGY-DIAGNOSTIC	750,552.00	0.00
CT SCAN	1,040,259.50	108,056.00
PHYSICAL THERAPY	375,970.50	0.00
EKG/ECG	268,503.50	0.00
IV THERAPY	7,716.75	116.75
OPERATING ROOM	1,816,286.00	6,456.50
LABOR/DELIVERY ROOM	254,893.25	0.00
RESPIRATORY SERVICES	1,221,982.25	2,885.75
ANESTHESIA	414,129.50	0.00
GI SERVICES	150,298.00	0.00
EMERGENCY ROOM	732,231.75	1,965.75
RECOVERY ROOM	314,766.75	0.00
LABORATORY PATHOLOGIC	82,191.75	0.00
RADIOLOGY THERAPEUTIC	1,383.50	0.00
OCCUPATIONAL THERAPY	300,850.50	0.00
SPEECH PATHOLOGY	127,005.25	0.00
RENAL DIALYSIS	77,691.00	52,078.75
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	253,309.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	269,865.25	467.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	147,316.50	9,189.50
AUDIOLOGY	10,939.00	0.00
CARDIOLOGY	1,688,754.95	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,449.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	57,707.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	147,207.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	59.25	0.00
OTHER THERAPEUTIC SVC	0.00	464.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	273,976.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	162,508.25
INJECTABLE DRUGS	5,103,915.15	7,693.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	244.50

TOTAL ANCILLARY	25,043,219.83	357,754.50
TOTAL ACCOMODATIONS	6,026,361.00	368,819.00
TOTAL CHARGES	31,069,580.83	726,573.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
5	4010286064949	09/21/10 - 09/21/10	10/25/10	0.00	244.50	0.00	0.00	0.00
TOTAL				0.00	244.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	250,596.00	ADJUSTMENTS	0.00
COVERED CHARGES	244,215.00	CONTRACTUAL ALLOW	149,789.56
NON-COVERD CHARGES	6,381.00	TOTAL MEDICAID LIAB	94,425.44
		LESS: COB	94,425.44
		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	28	0	21,028.00	3,304.00
ROUTINE NURSERY	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	28	0	21,028.00	3,304.00
SPECIAL CARE SERVICES				
CCU	7	0	7,236.00	0.00
ICU	2	0	2,618.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	9,854.00	0.00
TOTAL ACCOMODATIONS	37	0	30,882.00	3,304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,397.25	0.00
MED/SURG SUPPLY	9,957.00	0.00
LABORATORY-GENERAL	27,369.50	0.00
RADIOLOGY-DIAGNOSTIC	3,530.00	0.00
CT SCAN	8,213.25	3,077.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,259.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,396.50	0.00
LABOR/DELIVERY ROOM	21,315.50	0.00
RESPIRATORY SERVICES	13,644.00	0.00
ANESTHESIA	3,414.75	0.00
GI SERVICES	1,858.00	0.00
EMERGENCY ROOM	5,515.50	0.00
RECOVERY ROOM	13,855.00	0.00
LABORATORY PATHOLOGIC	1,184.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	788.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,767.50	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	17,319.25	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/OBSERV. RM	2,474.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,074.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	213,333.00	3,077.00
TOTAL ACCOMODATIONS	30,882.00	3,304.00
TOTAL CHARGES	244,215.00	6,381.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,378,135.85	ADJUSTMENTS	247,483.23
COVERED CHARGES	7,144,733.90	CONTRACTUAL ALLOW	5,780,740.83
NON-COVERD CHARGES	1,233,401.95	TOTAL MEDICAID LIAB	1,363,993.07
		LESS: COB	4,111.20
		LESS: COPAYMENT	2,159.03
		REIMBURSEMENT	1,357,722.84
		ALL OTHER	1,209,453.61
		FEE SCHEDULE-LAB	113,587.44
		INJECTABLE DRUGS	34,681.79

TOTAL NUMBER OF CLAIMS 2,936

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168,440.25	1,710.00
MED/SURG SUPPLY	207,085.36	62,484.50
LABORATORY-GENERAL	0.00	643.00
RADIOLOGY-DIAGNOSTIC	506,524.75	11,556.00
CT SCAN	932,395.25	107,785.50
PHYSICAL THERAPY	13,814.50	1,405.25
EKG/ECG	174,823.25	629.50
IV THERAPY	33,885.50	111.00
OPERATING ROOM	509,202.96	241,585.24
LABOR/DELIVERY ROOM	6,440.00	10,708.00
RESPIRATORY SERVICES	30,771.13	1,410.00
ANESTHESIA	175,913.50	0.00
GI SERVICES	190,451.89	32,069.37
EMERGENCY ROOM	1,436,837.75	5,388.50
RECOVERY ROOM	165,462.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	16,554.75	0.00
OCCUPATIONAL THERAPY	2,209.25	0.00
SPEECH PATHOLOGY	729.50	788.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,826.75	1,498.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	5,588.50	5,588.50
OTHER IMAGING SERVICE	196,810.86	23,911.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24,986.50	467.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	80,625.25	22,522.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	357,145.00	286,688.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	90,740.51	6,474.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,762.75	5,389.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	232.00	0.00
OTHER THERAPEUTIC SVC	0.00	944.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,387,194.74	224,509.29
MRI SERVICES	49,585.75	13,677.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	948.25
INJECTABLE DRUGS	309,693.70	162,509.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,144,733.90	1,233,401.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,144,733.90	1,233,401.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	250,399.69	ADJUSTMENTS	0.00
COVERED CHARGES	198,823.69	CONTRACTUAL ALLOW	134,834.73
NON-COVERD CHARGES	51,576.00	TOTAL MEDICAID LIAB	63,988.96
		LESS: COB	63,893.79
		LESS: COPAYMENT	95.17
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,820.25	0.00	OTHER LAB	1,734.00	0.00
MED/SURG SUPPLY	1,374.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,373.75	0.00	OTHER THERAPEUTIC SVC	0.00	714.00
CT SCAN	7,938.75	10,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,242.50	7,335.75
EKG/ECG	4,650.75	0.00	MRI SERVICES	4,943.75	3,419.25
IV THERAPY	1,916.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	309.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	596.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,262.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,918.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	400.25	8,251.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,799.50	468.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,244.50	6,581.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	40.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	6,739.19	1,372.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,900.50	12,400.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,438.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816.50	0.00			

TOTAL ANCILLARY	198,823.69	51,576.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	198,823.69	51,576.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	728,039.25	ADJUSTMENTS	5,465.86
COVERED CHARGES	689,686.25	CONTRACTUAL ALLOW	658,097.96
NON-COVERD CHARGES	38,353.00	TOTAL MEDICAID LIAB	31,588.29
		LESS: COB	0.00
		LESS: COPAYMENT	1,074.03
		REIMBURSEMENT	30,514.26

TOTAL NUMBER OF CLAIMS 564

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,644.50	62.50	OTHER LAB	3,972.50	986.25
MED/SURG SUPPLY	1,839.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,043.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,835.50	2,935.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133,744.75	24,406.50
EKG/ECG	10,269.25	0.00	MRI SERVICES	3,419.25	0.00
IV THERAPY	3,339.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,872.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	344,766.25	599.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,184.50	4,447.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	81.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	22,866.25	4,834.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,465.75	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	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	923.25	0.00			

TOTAL ANCILLARY	689,686.25	38,353.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	689,686.25	38,353.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,045.50	ADJUSTMENTS	0.00
COVERED CHARGES	12,006.25	CONTRACTUAL ALLOW	6,584.04
NON-COVERD CHARGES	1,039.25	TOTAL MEDICAID LIAB	5,422.21
		LESS: COB	5,404.21
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	392.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	411.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,311.25	264.50
EKG/ECG	629.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	126.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	122.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,921.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	920.75	774.75			
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	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,006.25	1,039.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,006.25	1,039.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	932,012.03	ADJUSTMENTS	32,129.38
COVERED CHARGES	830,894.85	CONTRACTUAL ALLOW	709,231.63
NON-COVERD CHARGES	101,117.18	TOTAL MEDICAID LIAB	121,663.22
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	121,549.22

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,983.05	0.00
MED/SURG SUPPLY	184,245.75	23,075.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,479.00	6,837.50
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,310.25	314.75
IV THERAPY	126.25	0.00
OPERATING ROOM	285,561.80	6,214.68
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,059.75	0.00
ANESTHESIA	60,161.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	27,721.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	818.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,038.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,347.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	127,964.25	40,240.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	727.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,488.75	6,320.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,210.00	16,767.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	830,894.85	101,117.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	830,894.85	101,117.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,395,413.93	ADJUSTMENTS	611,933.68
COVERED CHARGES	13,221,096.43	CONTRACTUAL ALLOW	9,500,566.15
NON-COVERD CHARGES	174,317.50	TOTAL MEDICAID LIAB	3,720,530.28
		LESS: COB	16,457.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,704,073.14

TOTAL NUMBER OF ADMISSIONS 519

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,433	1	765,050.00	58,408.00
ROUTINE NURSERY	192	0	103,975.00	82,880.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,625	1	869,025.00	141,288.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	843	4	1,024,719.00	7,160.00
NICU	1	0	2,184.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	844	4	1,026,903.00	7,160.00
TOTAL ACCOMODATIONS	2,469	5	1,895,928.00	148,448.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,750,831.98	1,380.00
MED/SURG SUPPLY	1,226,484.50	4,030.00
LABORATORY-GENERAL	2,429,125.00	158.00
RADIOLOGY-DIAGNOSTIC	316,985.70	0.00
CT SCAN	728,890.00	977.50
PHYSICAL THERAPY	131,984.00	0.00
EKG/ECG	87,722.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	956,428.50	0.00
LABOR/DELIVERY ROOM	312,338.00	0.00
RESPIRATORY SERVICES	695,847.00	0.00
ANESTHESIA	191,733.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	429,029.00	1,033.00
RECOVERY ROOM	178,122.00	0.00
LABORATORY PATHOLOGIC	25,826.00	0.00
RADIOLOGY THERAPEUTIC	4,067.75	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	29,823.00	0.00
RENAL DIALYSIS	43,137.00	7,975.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	588.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	74,053.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	177,541.00	4,612.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	80,089.00	0.00
AUDIOLOGY	13,782.00	0.00
CARDIOLOGY	232,100.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,060.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,827.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	79,591.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	105,337.00	5,116.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	414.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,325,168.43	25,869.50
TOTAL ACCOMODATIONS	1,895,928.00	148,448.00
TOTAL CHARGES	13,221,096.43	174,317.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,041.00	ADJUSTMENTS	0.00
COVERED CHARGES	996.00	CONTRACTUAL ALLOW	-194.00
NON-COVERD CHARGES	2,045.00	TOTAL MEDICAID LIAB	1,190.00
		LESS: COB	1,190.00
		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	0	0	0.00	0.00
ROUTINE NURSERY	0	2	0.00	1,360.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	0	2	0.00	1,360.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	0	2	0.00	1,360.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	221.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	90.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	996.00	203.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	171.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	996.00	685.00
TOTAL ACCOMODATIONS	0.00	1,360.00
TOTAL CHARGES	996.00	2,045.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,617,798.30	ADJUSTMENTS	537,972.67
COVERED CHARGES	9,711,807.30	CONTRACTUAL ALLOW	7,826,025.51
NON-COVERD CHARGES	905,991.00	TOTAL MEDICAID LIAB	1,885,781.79
		LESS: COB	5,619.88
		LESS: COPAYMENT	4,522.57
		REIMBURSEMENT	1,875,639.34
		ALL OTHER	1,743,718.10
		FEE SCHEDULE-LAB	128,116.18
		INJECTABLE DRUGS	3,805.06

TOTAL NUMBER OF CLAIMS 3,894

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	922,839.00	14,684.00
MED/SURG SUPPLY	477,629.00	7,654.00
LABORATORY-GENERAL	0.00	150.00
RADIOLOGY-DIAGNOSTIC	499,369.00	13,044.00
CT SCAN	1,303,657.00	140,886.00
PHYSICAL THERAPY	23,393.00	13,154.00
EKG/ECG	99,576.00	0.00
IV THERAPY	6,762.00	995.00
OPERATING ROOM	1,047,230.00	92,583.00
LABOR/DELIVERY ROOM	200,774.00	0.00
RESPIRATORY SERVICES	44,008.00	67,473.00
ANESTHESIA	208,941.00	973.00
GI SERVICES	1,324.00	0.00
EMERGENCY ROOM	1,436,076.00	45,808.00
RECOVERY ROOM	228,682.00	1,829.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	59,910.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	369.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	60,125.00	4,604.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	311,615.00	79,506.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	55,746.00	1,364.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	213,953.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	196,164.00	61,140.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,594.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	79,494.00	6,171.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	185,157.00	1,196.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,754,576.20	307,213.20
MRI SERVICES	169,989.00	10,227.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	123,224.10	25,366.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	7,674.00

TOTAL ANCILLARY	9,711,807.30	904,064.00
TOTAL ACCOMODATIONS	0.00	1,927.00
TOTAL CHARGES	9,711,807.30	905,991.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	5911031000822	01/13/11 - 01/13/11	02/07/11	0.00	2,558.00	0.00	0.00	0.00
615	5911062001244	02/09/11 - 02/09/11	03/07/11	0.00	2,558.00	0.00	0.00	0.00
618	5911188000384	03/31/11 - 03/31/11	07/11/11	0.00	2,558.00	0.00	0.00	0.00
TOTAL				0.00	7,674.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	133,847.00	ADJUSTMENTS	0.00
COVERED CHARGES	87,218.00	CONTRACTUAL ALLOW	38,455.17
NON-COVERD CHARGES	46,629.00	TOTAL MEDICAID LIAB	48,762.83
		LESS: COB	48,750.83
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,074.25	8.00
MED/SURG SUPPLY	2,328.75	419.00
LABORATORY-GENERAL	0.00	253.00
RADIOLOGY-DIAGNOSTIC	7,296.00	517.00
CT SCAN	6,909.00	22,963.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,730.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	4,996.00
LABOR/DELIVERY ROOM	3,307.00	4,209.00
RESPIRATORY SERVICES	694.00	0.00
ANESTHESIA	949.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,900.00	2,721.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,924.00	3,105.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,756.00	1,880.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,401.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	322.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	486.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,041.00	3,921.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	179.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,100.00	1,458.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	87,218.00	46,629.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,218.00	46,629.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	513,162.75	ADJUSTMENTS	4,600.81
COVERED CHARGES	476,787.75	CONTRACTUAL ALLOW	448,469.40
NON-COVERD CHARGES	36,375.00	TOTAL MEDICAID LIAB	28,318.35
		LESS: COB	0.00
		LESS: COPAYMENT	966.12
		REIMBURSEMENT	27,352.23

TOTAL NUMBER OF CLAIMS 506

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,110.75	540.00	OTHER LAB	4,686.00	598.00
MED/SURG SUPPLY	8,047.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,429.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,918.00	6,656.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110,646.00	18,272.00
EKG/ECG	3,900.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	597.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	402.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,317.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,307.00	3,868.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,993.00	3,031.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	9,435.00	3,338.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	476,787.75	36,375.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	476,787.75	36,375.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,127.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,351.00	CONTRACTUAL ALLOW	1,408.52
NON-COVERD CHARGES	776.00	TOTAL MEDICAID LIAB	3,942.48
		LESS: COB	3,939.48
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.00	0.00
MED/SURG SUPPLY	259.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	844.00	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	138.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,606.00	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 SERVICE	0.00	594.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,328.00	141.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	41.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,351.00	776.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,351.00	776.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	821,332.61	ADJUSTMENTS	89,653.36
COVERED CHARGES	802,532.61	CONTRACTUAL ALLOW	654,767.04
NON-COVERD CHARGES	18,800.00	TOTAL MEDICAID LIAB	147,765.57
		LESS: COB	0.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	147,549.57

TOTAL NUMBER OF CLAIMS 30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	284,020.69	150.00
MED/SURG SUPPLY	145,854.00	0.00
LABORATORY-GENERAL	0.00	90.00
RADIOLOGY-DIAGNOSTIC	3,422.00	1,239.00
CT SCAN	5,241.00	0.00
PHYSICAL THERAPY	0.00	500.00
EKG/ECG	1,498.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	170,729.00	5,883.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,416.00	0.00
ANESTHESIA	34,421.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,250.00	388.00
RECOVERY ROOM	26,192.00	0.00
LABORATORY PATHOLOGIC	0.00	159.00
RADIOLOGY THERAPEUTIC	34,302.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,951.00	579.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,646.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,898.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,385.00	1,596.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,932.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,189.00	3,039.00
MRI SERVICES	2,756.00	4,163.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,429.92	1,014.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	802,532.61	18,800.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	802,532.61	18,800.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,538,077.60	ADJUSTMENTS	4,471,975.64
COVERED CHARGES	66,149,970.46	CONTRACTUAL ALLOW	43,507,680.84
NON-COVERD CHARGES	2,388,107.14	TOTAL MEDICAID LIAB	22,642,289.62
		LESS: COB	94,837.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,547,451.92

TOTAL NUMBER OF ADMISSIONS 2,139

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9,970	132	10,754,739.00	308,513.00
ROUTINE NURSERY	1,087	5	1,022,415.00	3,550.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11,057	137	11,777,154.00	312,063.00
SPECIAL CARE SERVICES				
CCU	294	0	1,118,670.00	0.00
ICU	1,480	67	5,635,103.75	255,981.25
NICU	430	0	1,062,500.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,204	67	7,816,273.75	255,981.25
TOTAL ACCOMODATIONS	13,261	204	19,593,427.75	568,044.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,558,821.68	54,326.20
MED/SURG SUPPLY	5,235,937.00	125,330.00
LABORATORY-GENERAL	7,908,244.60	69,064.00
RADIOLOGY-DIAGNOSTIC	1,049,849.00	1,811.00
CT SCAN	2,131,279.00	40,973.00
PHYSICAL THERAPY	516,265.00	11,552.00
EKG/ECG	241,913.00	336.00
IV THERAPY	46,448.00	2,220.00
OPERATING ROOM	4,540,014.00	9,323.00
LABOR/DELIVERY ROOM	1,525,942.00	0.00
RESPIRATORY SERVICES	2,679,756.00	69,315.00
ANESTHESIA	1,246,961.00	1,344.00
GI SERVICES	284,497.00	0.00
EMERGENCY ROOM	1,627,169.00	17,813.00
RECOVERY ROOM	437,924.00	0.00
LABORATORY PATHOLOGIC	398,426.00	0.00
RADIOLOGY THERAPEUTIC	114,160.00	23,685.00
OCCUPATIONAL THERAPY	202,184.00	9,224.00
SPEECH PATHOLOGY	134,885.00	7,115.00
RENAL DIALYSIS	833,810.00	324,405.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	34.00	2,567.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	272,347.00	315,818.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,081,252.00	994.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	176,321.00	109,140.00
AUDIOLOGY	11,466.00	0.00
CARDIOLOGY	1,904,337.00	1,883.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	133,496.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	82,125.00	3,754.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	419,085.00	681.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,301,272.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	529,491.22
INJECTABLE DRUGS	3,460,322.43	87,898.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	46,556,542.71	1,820,062.89
TOTAL ACCOMODATIONS	19,593,427.75	568,044.25
TOTAL CHARGES	66,149,970.46	2,388,107.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	870,437.81	ADJUSTMENTS	0.00
COVERED CHARGES	868,102.81	CONTRACTUAL ALLOW	206,137.87
NON-COVERD CHARGES	2,335.00	TOTAL MEDICAID LIAB	661,964.94
		LESS: COB	661,964.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	79	3	80,986.00	2,221.00
ROUTINE NURSERY	39	0	43,265.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	118	3	124,251.00	2,221.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	94	0	230,300.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	94	0	230,300.00	0.00
TOTAL ACCOMODATIONS	212	3	354,551.00	2,221.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,080.91	0.00	OTHER LAB	3,729.00	0.00
MED/SURG SUPPLY	26,183.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	102,260.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,164.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,408.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,164.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	593.00	0.00	MRI SERVICES	7,693.00	0.00
IV THERAPY	573.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,839.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,719.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,772.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,375.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,267.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,059.00	0.00	INJECTABLE DRUGS	20,203.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,580.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	9,048.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,117.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,100.00	114.00			
AUDIOLOGY	107.00	0.00			
CARDIOLOGY	7,819.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	548.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	639.00	0.00			

TOTAL ANCILLARY	513,551.81	114.00
TOTAL ACCOMODATIONS	354,551.00	2,221.00
TOTAL CHARGES	868,102.81	2,335.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,183,641.68	ADJUSTMENTS	232,231.09
COVERED CHARGES	16,440,286.15	CONTRACTUAL ALLOW	12,369,310.25
NON-COVERD CHARGES	5,743,355.53	TOTAL MEDICAID LIAB	4,070,975.90
		LESS: COB	1,456.54
		LESS: COPAYMENT	13,927.84
		REIMBURSEMENT	4,055,591.52
		ALL OTHER	3,045,499.53
		FEE SCHEDULE-LAB	439,983.82
		INJECTABLE DRUGS	570,108.17

TOTAL NUMBER OF CLAIMS 7,711

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699,704.65	2,913.85
MED/SURG SUPPLY	605,716.75	267,544.00
LABORATORY-GENERAL	0.00	1,472.00
RADIOLOGY-DIAGNOSTIC	498,139.00	37,245.00
CT SCAN	1,087,581.00	608,713.00
PHYSICAL THERAPY	20,521.00	7,018.00
EKG/ECG	190,555.00	448.00
IV THERAPY	221,493.00	3,428.00
OPERATING ROOM	765,129.00	697,833.00
LABOR/DELIVERY ROOM	21,364.00	115.00
RESPIRATORY SERVICES	156,502.00	84,965.00
ANESTHESIA	323,075.00	0.00
GI SERVICES	62,708.00	27,858.00
EMERGENCY ROOM	2,560,684.86	81,211.00
RECOVERY ROOM	427,478.00	0.00
LABORATORY PATHOLOGIC	0.00	144.00
RADIOLOGY THERAPEUTIC	442,409.00	10,824.00
OCCUPATIONAL THERAPY	998.00	2,493.00
SPEECH PATHOLOGY	0.00	2,786.00
RENAL DIALYSIS	0.00	100,620.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	30,170.00	2,895.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	505,460.00	601,602.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	368,082.50	46,481.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	247,953.00	270,229.51
AUDIOLOGY	0.00	0.00
CARDIOLOGY	380,982.00	444,924.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,644.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	642,133.11	107,842.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	165,666.00	4,161.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,050.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,309,836.85	610,299.90
MRI SERVICES	805,246.00	185,282.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	16,847.20
INJECTABLE DRUGS	1,899,054.43	1,512,119.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	992.00

TOTAL ANCILLARY	16,440,286.15	5,743,355.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,440,286.15	5,743,355.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8005	5911076002162	09/08/10 - 09/08/10	03/21/11	0.00	101.00	0.00	613.08	0.00
8448	2211084016177	11/10/10 - 11/11/10	03/28/11	0.00	95.00	0.00	0.00	0.00
405	2211292012965	06/05/11 - 06/05/11	10/24/11	0.00	517.00	0.00	0.00	0.00
9637	5911325000285	04/07/11 - 04/07/11	11/28/11	0.00	279.00	0.00	0.00	0.00
TOTAL				0.00	992.00	0.00	613.08	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	168,835.42	ADJUSTMENTS	0.00
COVERED CHARGES	118,786.77	CONTRACTUAL ALLOW	51,268.92
NON-COVERD CHARGES	50,048.65	TOTAL MEDICAID LIAB	67,517.85
		LESS: COB	67,386.10
		LESS: COPAYMENT	131.75
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,634.27	0.00
MED/SURG SUPPLY	5,736.00	19,362.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,308.00	130.00
CT SCAN	10,585.00	2,073.00
PHYSICAL THERAPY	450.00	0.00
EKG/ECG	1,232.00	0.00
IV THERAPY	155.00	0.00
OPERATING ROOM	15,235.00	6,160.00
LABOR/DELIVERY ROOM	436.00	0.00
RESPIRATORY SERVICES	971.00	0.00
ANESTHESIA	4,172.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,942.00	279.00
RECOVERY ROOM	10,628.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,671.00	0.00
OCCUPATIONAL THERAPY	484.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	424.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,663.00	5,648.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,291.00	485.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	555.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,408.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,883.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	507.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,948.00	3,063.30
MRI SERVICES	4,869.00	2,390.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,154.50	9,903.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	118,786.77	50,048.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,786.77	50,048.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	598,375.71	ADJUSTMENTS	1,473.28
COVERED CHARGES	543,235.20	CONTRACTUAL ALLOW	498,651.03
NON-COVERD CHARGES	55,140.51	TOTAL MEDICAID LIAB	44,584.17
		LESS: COB	0.00
		LESS: COPAYMENT	2,121.07
		REIMBURSEMENT	42,463.10

TOTAL NUMBER OF CLAIMS 797

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,764.91	273.60
MED/SURG SUPPLY	3,852.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,655.00	130.00
CT SCAN	14,302.00	13,143.00
PHYSICAL THERAPY	0.00	450.00
EKG/ECG	9,296.00	0.00
IV THERAPY	988.00	0.00
OPERATING ROOM	1,284.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,668.00	198.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	305,224.00	3,984.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,920.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	68.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,553.00	4,660.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	136.00	124.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,189.00	143.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,550.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,179.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	116,242.00	29,029.30
MRI SERVICES	15,649.00	2,479.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,783.29	458.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	543,235.20	55,140.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	543,235.20	55,140.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,897.32	ADJUSTMENTS	0.00
COVERED CHARGES	6,873.32	CONTRACTUAL ALLOW	5,316.14
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	1,557.18
		LESS: COB	1,536.18
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	74.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	881.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,312.00	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,447.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,873.32	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,873.32	24.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,678,036.80	ADJUSTMENTS	134,821.35
COVERED CHARGES	3,355,742.85	CONTRACTUAL ALLOW	2,528,540.11
NON-COVERD CHARGES	322,293.95	TOTAL MEDICAID LIAB	827,202.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,482.69
		REIMBURSEMENT	825,720.05

TOTAL NUMBER OF CLAIMS 160

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,057.13	147.50
MED/SURG SUPPLY	189,249.00	13,309.00
LABORATORY-GENERAL	0.00	1,380.00
RADIOLOGY-DIAGNOSTIC	81,463.00	19,605.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,664.00
EKG/ECG	1,344.00	0.00
IV THERAPY	39,459.00	155.00
OPERATING ROOM	112,458.00	71,203.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	35,022.00	99.00
ANESTHESIA	13,874.00	0.00
GI SERVICES	0.00	1,391.00
EMERGENCY ROOM	3,322.00	0.00
RECOVERY ROOM	11,959.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	236,417.00	4,791.00
OCCUPATIONAL THERAPY	0.00	498.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,290.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	76.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	75.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	39,052.00	5,625.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,847.00	72.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	118,825.00	7,502.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,746.00	9,183.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,862.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	135,495.34	37,878.73
MRI SERVICES	32,048.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,208,168.38	146,424.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,355,742.85	322,293.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,355,742.85	322,293.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,649,252.19	ADJUSTMENTS	334,526.54
COVERED CHARGES	4,618,090.11	CONTRACTUAL ALLOW	2,249,902.77
NON-COVERD CHARGES	31,162.08	TOTAL MEDICAID LIAB	2,368,187.34
		LESS: COB	17,854.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,350,332.98

TOTAL NUMBER OF ADMISSIONS 376

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,226	0	754,674.25	0.00
ROUTINE NURSERY	82	0	67,440.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	8.00
TOTAL ROUTINE	1,308	0	822,114.25	8.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	343	0	428,406.00	0.00
NICU	2	0	2,200.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	345	0	430,606.00	0.00
TOTAL ACCOMODATIONS	1,653	0	1,252,720.25	8.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	394,959.26	0.00
MED/SURG SUPPLY	344,011.85	15,196.08
LABORATORY-GENERAL	698,697.25	0.00
RADIOLOGY-DIAGNOSTIC	88,808.50	0.00
CT SCAN	256,445.25	0.00
PHYSICAL THERAPY	24,749.50	0.00
EKG/ECG	36,733.75	0.00
IV THERAPY	41,066.75	0.00
OPERATING ROOM	240,356.25	0.00
LABOR/DELIVERY ROOM	40,203.75	0.00
RESPIRATORY SERVICES	140,581.75	0.00
ANESTHESIA	26,106.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	91,615.50	0.00
RECOVERY ROOM	38,340.25	0.00
LABORATORY PATHOLOGIC	7,447.25	0.00
RADIOLOGY THERAPEUTIC	91.50	0.00
OCCUPATIONAL THERAPY	2,131.00	0.00
SPEECH PATHOLOGY	2,748.00	0.00
RENAL DIALYSIS	10,800.00	6,180.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	484.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	22,080.00	3,902.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	97,702.50	5,167.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	30,334.25	223.75
AUDIOLOGY	5,694.00	0.00
CARDIOLOGY	82,603.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,749.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,664.95	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	18,003.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	31,071.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	588,574.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,365,369.86	31,154.08
TOTAL ACCOMODATIONS	1,252,720.25	8.00
TOTAL CHARGES	4,618,090.11	31,162.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	4410259134670	07/05/10 - 07/05/10	09/27/10	0.00	0.00	0.00	0.00	0.00
0	4410259134670	07/05/10 - 07/05/10	09/27/10	0.00	0.00	0.00	0.00	0.00
0	4410259134670	07/05/10 - 07/05/10	09/27/10	0.00	0.00	0.00	0.00	0.00
0	4410259134670	07/05/10 - 07/05/10	09/27/10	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,389.89	ADJUSTMENTS	0.00
COVERED CHARGES	47,389.89	CONTRACTUAL ALLOW	11,070.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	36,318.94
		LESS: COB	36,318.94
		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	10	0	7,500.00	0.00
ROUTINE NURSERY	2	0	1,650.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	9,150.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	5,000.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	5,000.00	0.00
TOTAL ACCOMODATIONS	16	0	14,150.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,767.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,607.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,510.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	328.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	363.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	75.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,329.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	308.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,002.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	566.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	654.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,138.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	113.00	0.00	INJECTABLE DRUGS	5,776.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,322.50	0.00			
AUDIOLOGY	146.00	0.00			
CARDIOLOGY	1,231.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	33,239.89	0.00
TOTAL ACCOMODATIONS	14,150.00	0.00
TOTAL CHARGES	47,389.89	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,600,393.59	ADJUSTMENTS	130,968.42
COVERED CHARGES	3,920,377.46	CONTRACTUAL ALLOW	2,927,249.41
NON-COVERD CHARGES	680,016.13	TOTAL MEDICAID LIAB	993,128.05
		LESS: COB	1,121.42
		LESS: COPAYMENT	7,190.83
		REIMBURSEMENT	984,815.80
		ALL OTHER	728,079.32
		FEE SCHEDULE-LAB	138,537.41
		INJECTABLE DRUGS	118,199.07

TOTAL NUMBER OF CLAIMS 4,395

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,250.60	39,787.65
MED/SURG SUPPLY	160,259.99	7,725.31
LABORATORY-GENERAL	0.00	406.59
RADIOLOGY-DIAGNOSTIC	226,561.75	3,149.00
CT SCAN	490,055.00	147,749.00
PHYSICAL THERAPY	39,899.00	14,098.75
EKG/ECG	41,892.75	485.00
IV THERAPY	97,534.50	892.75
OPERATING ROOM	333,928.76	87,613.00
LABOR/DELIVERY ROOM	154.25	0.00
RESPIRATORY SERVICES	7,302.75	240.00
ANESTHESIA	48,156.00	0.00
GI SERVICES	121.25	0.00
EMERGENCY ROOM	264,619.75	3,105.00
RECOVERY ROOM	52,234.00	14.15
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	30,018.50	538.75
OCCUPATIONAL THERAPY	11,468.75	2,501.00
SPEECH PATHOLOGY	3,084.00	2,590.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	21,407.50	1,159.80
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,847.00	0.00
OTHER IMAGING SERVICE	101,922.00	10,192.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,743.50	13,091.00
ONCOLOGY	2,469.00	0.00
NUCLEAR MEDICINE	119,441.25	11,914.25
AUDIOLOGY	146.00	292.00
CARDIOLOGY	87,727.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,809.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	97,317.93	19,109.08

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	115,055.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,010,264.57	195,257.25
MRI SERVICES	179,019.75	14,928.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	322,664.36	103,174.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,920,377.46	680,016.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,920,377.46	680,016.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,217.56	ADJUSTMENTS	0.00
COVERED CHARGES	76,302.04	CONTRACTUAL ALLOW	21,428.59
NON-COVERD CHARGES	19,915.52	TOTAL MEDICAID LIAB	54,873.45
		LESS: COB	54,812.91
		LESS: COPAYMENT	60.54
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	459.32	209.72
MED/SURG SUPPLY	3,496.44	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,937.00	0.00
CT SCAN	5,658.75	8,870.00
PHYSICAL THERAPY	5,157.75	0.00
EKG/ECG	363.75	0.00
IV THERAPY	1,286.50	0.00
OPERATING ROOM	10,659.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	908.00	0.00
ANESTHESIA	1,132.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,279.75	0.00
RECOVERY ROOM	2,021.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,661.75	0.00
SPEECH PATHOLOGY	2,056.00	456.50
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 SERVICE	1,944.00	972.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,673.75	447.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,793.25	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/OBSERV. RM	2,110.85	724.90

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,665.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,804.00	3,125.50
MRI SERVICES	0.00	2,913.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	233.43	2,195.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	76,302.04	19,915.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	76,302.04	19,915.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	220,103.12	ADJUSTMENTS	1,674.95
COVERED CHARGES	196,111.65	CONTRACTUAL ALLOW	176,087.32
NON-COVERD CHARGES	23,991.47	TOTAL MEDICAID LIAB	20,024.33
		LESS: COB	0.00
		LESS: COPAYMENT	780.07
		REIMBURSEMENT	19,244.26

TOTAL NUMBER OF CLAIMS 358

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.25	1,084.17
MED/SURG SUPPLY	4,141.65	53.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,153.50	164.00
CT SCAN	17,059.75	10,109.50
PHYSICAL THERAPY	0.00	239.50
EKG/ECG	4,728.75	121.25
IV THERAPY	6,031.00	0.00
OPERATING ROOM	0.00	3,863.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	353.25	0.00
ANESTHESIA	355.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	68,713.25	243.25
RECOVERY ROOM	505.25	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	323.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,330.25	1,216.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,231.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,127.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,650.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,208.75	5,503.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,118.75	1,393.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	196,111.65	23,991.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	196,111.65	23,991.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,090.13	ADJUSTMENTS	0.00
COVERED CHARGES	7,878.78	CONTRACTUAL ALLOW	3,833.47
NON-COVERD CHARGES	211.35	TOTAL MEDICAID LIAB	4,045.31
		LESS: COB	4,033.31
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,267.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,392.25	154.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,312.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.03	56.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	729.50	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,878.78	211.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,878.78	211.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,667.99	ADJUSTMENTS	4,470.28
COVERED CHARGES	47,155.30	CONTRACTUAL ALLOW	33,790.71
NON-COVERD CHARGES	1,512.69	TOTAL MEDICAID LIAB	13,364.59
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	13,358.59

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247.54	338.99
MED/SURG SUPPLY	11,415.35	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	453.50	121.50
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	160.00
EKG/ECG	0.00	0.00
IV THERAPY	1,186.75	0.00
OPERATING ROOM	17,582.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37.75	0.00
ANESTHESIA	1,569.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,515.75	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	9,847.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	572.25	200.75
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	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,941.33	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	222.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	564.83	691.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	47,155.30	1,512.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,155.30	1,512.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,122,452.57	ADJUSTMENTS	247,641.54
COVERED CHARGES	955,868.17	CONTRACTUAL ALLOW	503,839.87
NON-COVERD CHARGES	166,584.40	TOTAL MEDICAID LIAB	452,028.30
		LESS: COB	1,158.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	450,869.91

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	191	0	129,880.00	156,056.00
ROUTINE NURSERY	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	129,880.00	156,056.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	63	0	110,395.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	63	0	110,395.00	0.00
TOTAL ACCOMODATIONS	254	0	240,275.00	156,056.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,785.30	0.00
MED/SURG SUPPLY	60,770.28	2,391.80
LABORATORY-GENERAL	56,332.15	1,703.00
RADIOLOGY-DIAGNOSTIC	15,493.00	0.00
CT SCAN	941.00	0.00
PHYSICAL THERAPY	22,335.00	0.00
EKG/ECG	1,755.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,153.00	2,029.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	269,297.00	783.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,031.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	677.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,285.00	0.00
SPEECH PATHOLOGY	19,244.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	49.70	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	449.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,848.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,484.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	38.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	71,663.74	3,583.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	715,593.17	10,528.40
TOTAL ACCOMODATIONS	240,275.00	156,056.00
TOTAL CHARGES	955,868.17	166,584.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,327,734.09	ADJUSTMENTS	3,774,945.94
COVERED CHARGES	50,810,300.66	CONTRACTUAL ALLOW	30,806,717.31
NON-COVERD CHARGES	1,517,433.43	TOTAL MEDICAID LIAB	20,003,583.35
		LESS: COB	281,258.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,722,325.34

TOTAL NUMBER OF ADMISSIONS 4,011

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,682	54	8,119,603.00	835,431.00
ROUTINE NURSERY	3,602	0	2,311,602.00	69,500.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	0.00
TOTAL ROUTINE	15,284	60	10,431,205.00	904,931.00
SPECIAL CARE SERVICES				
CCU	12	0	2,309.00	0.00
ICU	1,605	0	2,722,399.00	3,712.00
NICU	576	0	991,448.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	47	0.00	39,535.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,193	47	3,716,156.00	43,247.00
TOTAL ACCOMODATIONS	17,477	107	14,147,361.00	948,178.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,075,293.48	24,027.40
MED/SURG SUPPLY	1,732,523.48	33,019.61
LABORATORY-GENERAL	6,729,280.03	45,415.11
RADIOLOGY-DIAGNOSTIC	853,770.30	4,848.00
CT SCAN	1,268,999.08	60,470.00
PHYSICAL THERAPY	357,079.00	27,802.00
EKG/ECG	347,205.00	270.00
IV THERAPY	239,546.22	3,071.00
OPERATING ROOM	1,612,334.33	30,491.00
LABOR/DELIVERY ROOM	2,736,675.81	0.00
RESPIRATORY SERVICES	3,374,852.50	23,257.00
ANESTHESIA	429,782.00	6,952.00
GI SERVICES	178,032.00	0.00
EMERGENCY ROOM	1,494,283.00	6,409.00
RECOVERY ROOM	1,085,415.50	2,612.00
LABORATORY PATHOLOGIC	251,198.00	0.00
RADIOLOGY THERAPEUTIC	107,182.00	0.00
OCCUPATIONAL THERAPY	126,123.00	7,469.00
SPEECH PATHOLOGY	132,120.00	351.00
RENAL DIALYSIS	160,557.00	34,481.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	68.00	656.00
PSYCHIATRIC SERVICES	166,767.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	546,845.00	4,862.00
BLOOD	1,976.00	0.00
BLOOD STORAGE & PRO.	688,003.50	8,579.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	292,455.00	69,167.75
AUDIOLOGY	122,692.00	0.00
CARDIOLOGY	873,993.70	0.00
AMBULATORY SURGERY	805.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	54,642.00	773.00
ORGAN ACQUISITION	0.00	872.00
TREATMENT/OBSERV. RM	89,632.00	6,931.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	704,524.00	1,592.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	12,150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	298,441.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,529,843.73	152,563.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	164.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	36,662,939.66	569,255.43
TOTAL ACCOMODATIONS	14,147,361.00	948,178.00
TOTAL CHARGES	50,810,300.66	1,517,433.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,029,914.82	ADJUSTMENTS	0.00
COVERED CHARGES	979,205.22	CONTRACTUAL ALLOW	588,792.66
NON-COVERD CHARGES	50,709.60	TOTAL MEDICAID LIAB	390,412.56
		LESS: COB	390,412.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	119	4	76,398.00	12,972.00
ROUTINE NURSERY	47	0	56,770.00	44.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	166	4	133,168.00	13,016.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	71	0	120,760.00	0.00
NICU	21	0	36,078.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	92	0	156,838.00	0.00
TOTAL ACCOMODATIONS	258	4	290,006.00	13,016.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,924.33	10,456.90
MED/SURG SUPPLY	22,754.89	743.00
LABORATORY-GENERAL	116,945.00	5,757.00
RADIOLOGY-DIAGNOSTIC	17,476.53	1,712.00
CT SCAN	9,855.00	4,170.00
PHYSICAL THERAPY	7,087.00	772.00
EKG/ECG	3,945.00	270.00
IV THERAPY	1,427.00	714.00
OPERATING ROOM	22,861.00	0.00
LABOR/DELIVERY ROOM	41,552.00	0.00
RESPIRATORY SERVICES	135,333.00	74.00
ANESTHESIA	4,817.00	0.00
GI SERVICES	11,470.00	0.00
EMERGENCY ROOM	5,617.00	1,119.00
RECOVERY ROOM	14,495.00	0.00
LABORATORY PATHOLOGIC	3,095.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,130.00	0.00
SPEECH PATHOLOGY	4,847.00	1,586.00
RENAL DIALYSIS	14,730.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	296.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,088.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,730.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,559.00	114.00
AUDIOLOGY	752.00	0.00
CARDIOLOGY	17,794.00	1,242.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	5,227.00
TREATMENT/OBSERV. RM	2,206.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,487.00	796.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,147.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	301.90
INJECTABLE DRUGS	67,074.47	2,342.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	689,199.22	37,693.60
TOTAL ACCOMODATIONS	290,006.00	13,016.00
TOTAL CHARGES	979,205.22	50,709.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,740,862.26	ADJUSTMENTS	1,346,561.98
COVERED CHARGES	15,798,624.99	CONTRACTUAL ALLOW	12,320,813.03
NON-COVERD CHARGES	1,942,237.27	TOTAL MEDICAID LIAB	3,477,811.96
		LESS: COB	7,752.37
		LESS: COPAYMENT	6,726.87
		REIMBURSEMENT	3,463,332.72
		ALL OTHER	2,980,416.78
		FEE SCHEDULE-LAB	298,708.74
		INJECTABLE DRUGS	184,207.20

TOTAL NUMBER OF CLAIMS 7,764

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413,491.86	121,423.46
MED/SURG SUPPLY	383,681.48	96,799.00
LABORATORY-GENERAL	0.00	190.00
RADIOLOGY-DIAGNOSTIC	806,007.92	54,837.03
CT SCAN	1,058,346.63	211,339.95
PHYSICAL THERAPY	13,051.00	4,094.00
EKG/ECG	259,708.00	775.00
IV THERAPY	374,645.10	6,900.00
OPERATING ROOM	1,181,164.77	252,623.08
LABOR/DELIVERY ROOM	435,927.00	0.00
RESPIRATORY SERVICES	83,210.00	26,439.00
ANESTHESIA	260,394.00	6,879.00
GI SERVICES	101,463.00	13,566.00
EMERGENCY ROOM	2,683,592.00	36,240.00
RECOVERY ROOM	552,838.00	1,440.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	373,804.00	14,712.00
OCCUPATIONAL THERAPY	2,707.00	2,809.00
SPEECH PATHOLOGY	1,936.00	1,687.00
RENAL DIALYSIS	0.00	11,354.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,055.00	255.00
PSYCHIATRIC SERVICES	57,360.00	0.00
LITHOTRIPSY	31,282.00	0.00
OTHER IMAGING SERVICE	1,289,443.00	92,929.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	75,943.00	42,287.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	183,523.00	67,693.92
AUDIOLOGY	3,195.00	1,653.00
CARDIOLOGY	276,928.64	133,681.90
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	24,559.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	632,125.85	389.64

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	590,405.00	3,945.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,854.00	748.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,685,937.50	452,731.80
MRI SERVICES	241,787.00	23,960.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	707,259.24	257,855.49
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,798,624.99	1,942,237.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,798,624.99	1,942,237.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	264,375.30	ADJUSTMENTS	0.00
COVERED CHARGES	194,402.00	CONTRACTUAL ALLOW	88,848.33
NON-COVERD CHARGES	69,973.30	TOTAL MEDICAID LIAB	105,553.67
		LESS: COB	105,487.19
		LESS: COPAYMENT	66.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,491.00	1,298.20
MED/SURG SUPPLY	5,136.00	35,188.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,239.00	651.00
CT SCAN	9,231.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,480.00	0.00
IV THERAPY	6,253.00	0.00
OPERATING ROOM	11,465.00	12,741.00
LABOR/DELIVERY ROOM	28,002.00	0.00
RESPIRATORY SERVICES	1,690.00	145.00
ANESTHESIA	4,373.00	0.00
GI SERVICES	2,941.00	0.00
EMERGENCY ROOM	26,148.00	444.00
RECOVERY ROOM	11,484.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	34.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,916.00	5,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,302.00	6,962.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,045.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,651.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,174.00	5,937.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,381.00	1,069.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4.00

TOTAL ANCILLARY	194,402.00	69,973.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,402.00	69,973.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	5911203000141	09/23/10 - 09/23/10	07/25/11	0.00	4.00	0.00	1,615.40	0.00
TOTAL				0.00	4.00	0.00	1,615.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,298,216.94	ADJUSTMENTS	14,093.29
COVERED CHARGES	1,194,682.68	CONTRACTUAL ALLOW	1,133,807.25
NON-COVERD CHARGES	103,534.26	TOTAL MEDICAID LIAB	60,875.43
		LESS: COB	0.01
		LESS: COPAYMENT	1,989.10
		REIMBURSEMENT	58,886.32

TOTAL NUMBER OF CLAIMS 1,088

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,037.30	2,381.60
MED/SURG SUPPLY	7,666.50	271.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,572.00	1,723.26
CT SCAN	35,893.00	15,924.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	21,585.00	0.00
IV THERAPY	20,026.00	0.00
OPERATING ROOM	3,542.00	3,303.00
LABOR/DELIVERY ROOM	15,338.00	0.00
RESPIRATORY SERVICES	3,882.00	145.00
ANESTHESIA	1,692.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	548,029.00	2,016.00
RECOVERY ROOM	3,693.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,167.00	1,992.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	190.00
PSYCHIATRIC SERVICES	10,883.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	96,041.00	16,543.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	872.00	720.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,242.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,659.00	880.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	18,437.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	287,456.00	47,296.00
MRI SERVICES	6,939.00	2,148.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,030.88	8,001.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,194,682.68	103,534.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,194,682.68	103,534.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,239.50	ADJUSTMENTS	0.00
COVERED CHARGES	30,470.60	CONTRACTUAL ALLOW	17,379.37
NON-COVERD CHARGES	1,768.90	TOTAL MEDICAID LIAB	13,091.23
		LESS: COB	13,076.23
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	471.50	0.00	OTHER LAB	198.00	0.00
MED/SURG SUPPLY	442.00	143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	780.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,315.00	691.00
EKG/ECG	505.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	547.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	126.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,946.00	136.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,379.10	78.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	52.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	257.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,078.00	542.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,552.00	0.00			

TOTAL ANCILLARY	30,470.60	1,768.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,470.60	1,768.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,385,950.29	ADJUSTMENTS	317,104.34
COVERED CHARGES	3,289,439.75	CONTRACTUAL ALLOW	2,581,404.71
NON-COVERD CHARGES	96,510.54	TOTAL MEDICAID LIAB	708,035.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,287.48
		REIMBURSEMENT	706,747.56

TOTAL NUMBER OF CLAIMS 140

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,951.00	30,973.90
MED/SURG SUPPLY	94,594.00	4,101.00
LABORATORY-GENERAL	0.00	162.00
RADIOLOGY-DIAGNOSTIC	30,071.00	2,408.00
CT SCAN	4,605.00	921.00
PHYSICAL THERAPY	0.00	1,866.00
EKG/ECG	1,785.00	0.00
IV THERAPY	92,324.50	0.00
OPERATING ROOM	184,700.00	22,828.64
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	22,589.00	0.00
ANESTHESIA	39,195.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	805.00	0.00
RECOVERY ROOM	51,384.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	507,058.00	3,070.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,265.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,583.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	53,961.00	0.00
OTHER IMAGING SERVICE	5,929.00	542.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,171.00	753.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	920.00	1,115.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,080.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,946.27	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	65,852.00	3,142.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,953,935.98	22,363.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,289,439.75	96,510.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,289,439.75	96,510.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
PO BOX 102204
ATLANTA,GA 30368-2204

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,575,383.58	ADJUSTMENTS	590,355.79
COVERED CHARGES	9,373,574.88	CONTRACTUAL ALLOW	5,690,539.54
NON-COVERD CHARGES	201,808.70	TOTAL MEDICAID LIAB	3,683,035.34
		LESS: COB	31,159.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,651,875.99

TOTAL NUMBER OF ADMISSIONS 467

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,901	10	1,356,600.00	135,246.00
ROUTINE NURSERY	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	1,901	10	1,356,600.00	135,246.00
SPECIAL CARE SERVICES				
CCU	21	0	18,406.00	0.00
ICU	342	0	611,604.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	363	0	630,010.00	0.00
TOTAL ACCOMODATIONS	2,264	10	1,986,610.00	135,246.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,119,613.76	0.00
MED/SURG SUPPLY	361,383.12	0.00
LABORATORY-GENERAL	1,421,613.92	537.00
RADIOLOGY-DIAGNOSTIC	214,832.54	0.00
CT SCAN	463,032.21	7,821.00
PHYSICAL THERAPY	68,188.00	948.00
EKG/ECG	89,680.00	0.00
IV THERAPY	227,671.00	396.00
OPERATING ROOM	330,353.13	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	486,977.00	0.00
ANESTHESIA	77,621.00	0.00
GI SERVICES	60,565.00	0.00
EMERGENCY ROOM	393,444.00	0.00
RECOVERY ROOM	71,589.00	0.00
LABORATORY PATHOLOGIC	43,694.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,266.00	0.00
SPEECH PATHOLOGY	16,212.00	0.00
RENAL DIALYSIS	62,357.00	19,149.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	5,808.00
PSYCHIATRIC SERVICES	5,570.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	487,011.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	140,945.00	1,440.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	89,166.00	21,012.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	253,230.70	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,702.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,185.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	77,489.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	199.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	142,648.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	651,925.50	9,252.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,386,964.88	66,562.70
TOTAL ACCOMODATIONS	1,986,610.00	135,246.00
TOTAL CHARGES	9,373,574.88	201,808.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,386,103.18	ADJUSTMENTS	551,474.67
COVERED CHARGES	6,659,209.65	CONTRACTUAL ALLOW	5,066,026.79
NON-COVERD CHARGES	726,893.53	TOTAL MEDICAID LIAB	1,593,182.86
		LESS: COB	2,089.25
		LESS: COPAYMENT	1,713.00
		REIMBURSEMENT	1,589,380.61
		ALL OTHER	1,432,260.42
		FEE SCHEDULE-LAB	139,520.48
		INJECTABLE DRUGS	17,599.71

TOTAL NUMBER OF CLAIMS 4,312

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125,880.03	13,186.16
MED/SURG SUPPLY	185,583.50	6,479.00
LABORATORY-GENERAL	0.00	286.00
RADIOLOGY-DIAGNOSTIC	456,053.63	17,221.58
CT SCAN	472,648.26	199,915.69
PHYSICAL THERAPY	4,162.00	2,326.00
EKG/ECG	112,735.00	270.00
IV THERAPY	327,485.00	17,830.00
OPERATING ROOM	273,794.00	73,337.00
LABOR/DELIVERY ROOM	7,742.00	0.00
RESPIRATORY SERVICES	34,543.00	5,722.00
ANESTHESIA	107,127.00	1,962.00
GI SERVICES	85,420.00	43,678.00
EMERGENCY ROOM	1,773,556.00	2,391.00
RECOVERY ROOM	121,072.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	89.00	790.00
SPEECH PATHOLOGY	0.00	724.00
RENAL DIALYSIS	0.00	511.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	26,902.00	601.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	567,961.00	31,932.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,714.00	2,979.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	65,229.00	11,920.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	67,132.00	2,066.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,446.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	191,676.00	39.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	82,640.00	2,670.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,359,212.23	240,621.90
MRI SERVICES	122,841.00	18,200.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,566.00	29,235.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,659,209.65	726,893.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,659,209.65	726,893.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,172.70	ADJUSTMENTS	0.00
COVERED CHARGES	57,544.50	CONTRACTUAL ALLOW	33,893.94
NON-COVERD CHARGES	7,628.20	TOTAL MEDICAID LIAB	23,650.56
		LESS: COB	23,633.92
		LESS: COPAYMENT	16.64
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,311.60	177.10
MED/SURG SUPPLY	1,542.00	343.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,709.00	350.00
CT SCAN	3,938.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,480.00	0.00
IV THERAPY	3,657.00	100.00
OPERATING ROOM	4,646.50	1,140.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	525.00	0.00
ANESTHESIA	3,136.00	0.00
GI SERVICES	0.00	1,502.00
EMERGENCY ROOM	15,245.00	34.00
RECOVERY ROOM	1,715.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	257.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,821.00	1,686.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,998.00	1,793.00
MRI SERVICES	1,393.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	170.40	502.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	57,544.50	7,628.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,544.50	7,628.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	936,791.03	ADJUSTMENTS	10,770.08
COVERED CHARGES	878,307.05	CONTRACTUAL ALLOW	826,618.50
NON-COVERD CHARGES	58,483.98	TOTAL MEDICAID LIAB	51,688.55
		LESS: COB	0.00
		LESS: COPAYMENT	1,392.03
		REIMBURSEMENT	50,296.52

TOTAL NUMBER OF CLAIMS 924

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,638.15	1,923.70
MED/SURG SUPPLY	7,957.00	91.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,611.00	0.00
CT SCAN	30,191.00	10,898.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	13,410.00	0.00
IV THERAPY	43,990.00	725.00
OPERATING ROOM	396.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,011.00	145.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	420,479.00	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	7,377.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,843.00	7,217.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	872.00	753.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	929.00	36.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	814.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,016.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	211,376.00	33,823.00
MRI SERVICES	3,181.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,215.90	2,872.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	878,307.05	58,483.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	878,307.05	58,483.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,460.20	ADJUSTMENTS	0.00
COVERED CHARGES	7,949.40	CONTRACTUAL ALLOW	6,713.79
NON-COVERD CHARGES	510.80	TOTAL MEDICAID LIAB	1,235.61
		LESS: COB	1,229.60
		LESS: COPAYMENT	6.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	412.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	995.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,276.00	291.00
EKG/ECG	270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,384.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	232.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,061.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.50	219.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,949.40	510.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,949.40	510.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	122,680.30	ADJUSTMENTS	14,886.78
COVERED CHARGES	117,477.20	CONTRACTUAL ALLOW	87,646.71
NON-COVERD CHARGES	5,203.10	TOTAL MEDICAID LIAB	29,830.49
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	29,812.49

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,181.10	4.00
MED/SURG SUPPLY	18,270.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,700.00	0.00
CT SCAN	0.00	2,320.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	540.00	0.00
IV THERAPY	901.00	0.00
OPERATING ROOM	39,649.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	565.00	0.00
ANESTHESIA	14,685.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,210.00	0.00
RECOVERY ROOM	6,123.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,178.00	542.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,744.00	720.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,814.00	502.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,776.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,871.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,450.00	668.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,819.50	447.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	117,477.20	5,203.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,477.20	5,203.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,336,352.57	ADJUSTMENTS	8,105,837.59
COVERED CHARGES	62,890,166.92	CONTRACTUAL ALLOW	50,189,007.18
NON-COVERD CHARGES	1,446,185.65	TOTAL MEDICAID LIAB	12,701,159.74
		LESS: COB	57,153.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,644,005.85

TOTAL NUMBER OF ADMISSIONS 737

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,384	5	1,154,480.00	604,154.00
ROUTINE NURSERY	288	0	296,255.00	80,708.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	1,672	7	1,450,735.00	684,862.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,333	11	2,618,934.00	57,825.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1,017	0	6,136,467.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	53	0.00	62,422.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,350	64	8,755,401.00	120,247.00
TOTAL ACCOMODATIONS	4,022	71	10,206,136.00	805,109.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,218,000.43	99,181.08
MED/SURG SUPPLY	10,630,285.03	77,311.99
LABORATORY-GENERAL	9,151,694.68	67,311.67
RADIOLOGY-DIAGNOSTIC	782,787.32	853.02
CT SCAN	621,212.62	7,481.14
PHYSICAL THERAPY	200,543.20	3,857.14
EKG/ECG	129,112.30	0.00
IV THERAPY	41,022.41	1,755.95
OPERATING ROOM	7,469,763.42	0.00
LABOR/DELIVERY ROOM	96,179.70	0.00
RESPIRATORY SERVICES	3,205,244.67	2,932.55
ANESTHESIA	0.00	0.00
GI SERVICES	187,139.28	10,735.60
EMERGENCY ROOM	367,018.21	5,480.13
RECOVERY ROOM	789,205.27	0.00
LABORATORY PATHOLOGIC	221,076.54	0.00
RADIOLOGY THERAPEUTIC	54,519.37	0.00
OCCUPATIONAL THERAPY	189,387.50	1,447.74
SPEECH PATHOLOGY	12,914.49	4,137.00
RENAL DIALYSIS	273,661.97	2,643.09
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	262.30	27,620.41
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	16,153.62	0.00
OTHER IMAGING SERVICE	195,428.01	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,443,870.34	1,143.99
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	143,787.56	1,022.63
AUDIOLOGY	84.57	10,133.05
CARDIOLOGY	341,581.67	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,501.12	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,353.12	4,899.42

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	215,381.54	3,626.94
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	481.60	29.51
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	90,786.43	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,544,590.63	305,651.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	1,820.66
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	52,684,030.92	641,076.65
TOTAL ACCOMODATIONS	10,206,136.00	805,109.00
TOTAL CHARGES	62,890,166.92	1,446,185.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,111.04	ADJUSTMENTS	0.00
COVERED CHARGES	98,442.49	CONTRACTUAL ALLOW	13,006.54
NON-COVERD CHARGES	71,668.55	TOTAL MEDICAID LIAB	85,435.95
		LESS: COB	85,435.95
		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	12	8	9,798.00	23,233.00
ROUTINE NURSERY	2	0	1,570.00	262.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14	8	11,368.00	23,495.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	14	8	11,368.00	23,495.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,193.42	9,371.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,456.32	3,806.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,755.17	8,475.05	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	248.01	1,443.43	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	712.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	472.18	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,921.19	1,361.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	324.00	13,081.71	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,878.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	782.82	0.00	INJECTABLE DRUGS	2,756.20	8,565.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,046.70	606.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	911.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	78.31			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	87,074.49	48,173.55
TOTAL ACCOMODATIONS	11,368.00	23,495.00
TOTAL CHARGES	98,442.49	71,668.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,174,173.39	ADJUSTMENTS	307,763.94
COVERED CHARGES	8,893,667.55	CONTRACTUAL ALLOW	7,057,099.78
NON-COVERD CHARGES	1,280,505.84	TOTAL MEDICAID LIAB	1,836,567.77
		LESS: COB	10,589.65
		LESS: COPAYMENT	5,822.09
		REIMBURSEMENT	1,820,156.03
		ALL OTHER	1,702,700.88
		FEE SCHEDULE-LAB	86,025.82
		INJECTABLE DRUGS	31,429.33

TOTAL NUMBER OF CLAIMS 4,241

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	336,224.72	4,019.19
MED/SURG SUPPLY	654,343.06	5,559.85
LABORATORY-GENERAL	0.00	45.18
RADIOLOGY-DIAGNOSTIC	455,436.64	1,995.85
CT SCAN	496,106.78	71,733.77
PHYSICAL THERAPY	36,381.79	17,521.29
EKG/ECG	118,525.60	0.00
IV THERAPY	96,344.46	39,796.77
OPERATING ROOM	1,910,652.69	703,593.41
LABOR/DELIVERY ROOM	149,364.99	35,339.21
RESPIRATORY SERVICES	63,601.74	606.94
ANESTHESIA	0.00	0.00
GI SERVICES	201,443.93	50,384.59
EMERGENCY ROOM	1,421,814.25	20,965.92
RECOVERY ROOM	651,496.66	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	251,878.49	4,784.42
OCCUPATIONAL THERAPY	13,377.73	12,998.46
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	146,925.09	7,921.71
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	282,519.89	4,072.99
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,333.68	1,073.58
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	151,140.35	17,881.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	57,957.58	12,162.73
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	129,343.34	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	197,540.57	117,027.83

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	47,748.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,863.60	59.02
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	701,921.89	118,135.03
MRI SERVICES	116,281.54	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	192,098.49	32,752.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	74.48
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,893,667.55	1,280,505.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,893,667.55	1,280,505.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	358,670.73	ADJUSTMENTS	0.00
COVERED CHARGES	245,701.60	CONTRACTUAL ALLOW	157,318.70
NON-COVERD CHARGES	112,969.13	TOTAL MEDICAID LIAB	88,382.90
		LESS: COB	88,317.78
		LESS: COPAYMENT	65.12
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,733.47	1,192.45
MED/SURG SUPPLY	23,079.24	0.00
LABORATORY-GENERAL	0.00	45.18
RADIOLOGY-DIAGNOSTIC	8,266.90	0.00
CT SCAN	0.00	7,498.73
PHYSICAL THERAPY	0.00	772.55
EKG/ECG	4,225.75	0.00
IV THERAPY	6,276.77	0.00
OPERATING ROOM	77,047.96	69,161.06
LABOR/DELIVERY ROOM	4,516.29	16,640.73
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,233.79	0.00
EMERGENCY ROOM	40,677.87	2,354.19
RECOVERY ROOM	30,322.60	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	1,699.69	558.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,795.92	1,886.75
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	2,830.40	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/OBSERV. RM	3,240.43	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,411.01	3,669.64
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,343.51	9,188.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	245,701.60	112,969.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	245,701.60	112,969.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	351,001.16	ADJUSTMENTS	3,021.70
COVERED CHARGES	342,740.28	CONTRACTUAL ALLOW	323,448.36
NON-COVERD CHARGES	8,260.88	TOTAL MEDICAID LIAB	19,291.92
		LESS: COB	0.00
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	18,682.92

TOTAL NUMBER OF CLAIMS 354

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,294.83	63.41	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,881.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,351.28	328.67	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,359.14	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,271.13	6,305.99
EKG/ECG	5,717.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,035.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,688.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	239,834.07	864.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,682.46	181.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	223.66	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	12,400.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	516.92			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	342,740.28	8,260.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,740.28	8,260.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,636.20	ADJUSTMENTS	0.00
COVERED CHARGES	5,405.98	CONTRACTUAL ALLOW	4,045.02
NON-COVERD CHARGES	230.22	TOTAL MEDICAID LIAB	1,360.96
		LESS: COB	1,360.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	198.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	175.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	328.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	571.25	33.38
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	120.47	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,011.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	196.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,405.98	230.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,405.98	230.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,923,848.11	ADJUSTMENTS	30,583.32
COVERED CHARGES	1,787,663.89	CONTRACTUAL ALLOW	1,511,310.68
NON-COVERD CHARGES	136,184.22	TOTAL MEDICAID LIAB	276,353.21
		LESS: COB	0.00
		LESS: COPAYMENT	663.00
		REIMBURSEMENT	275,690.21

TOTAL NUMBER OF CLAIMS 57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,845.87	0.00
MED/SURG SUPPLY	298,350.41	48,180.93
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,082.22	294.53
CT SCAN	19,287.31	0.00
PHYSICAL THERAPY	0.00	207.17
EKG/ECG	4,325.16	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	633,663.50	77,197.03
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,690.03	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,792.85	26.23
RECOVERY ROOM	154,686.78	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	481,862.95	1,334.34
OCCUPATIONAL THERAPY	0.00	795.24
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,234.62	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,544.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	886.46
AUDIOLOGY	0.00	0.00
CARDIOLOGY	58,178.90	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/OBSERV. RM	15,390.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	31.87
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,873.63	1,660.56
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,854.47	5,569.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,787,663.89	136,184.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,787,663.89	136,184.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
PO BOX 923508
NORCROSS,GA 30010-3508

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,353,051.02	ADJUSTMENTS	45,944.49
COVERED CHARGES	2,196,153.62	CONTRACTUAL ALLOW	904,305.40
NON-COVERD CHARGES	156,897.40	TOTAL MEDICAID LIAB	1,291,848.22
		LESS: COB	16,689.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,275,158.98

TOTAL NUMBER OF ADMISSIONS 230

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	583	1	244,050.00	136,620.00
ROUTINE NURSERY	66	0	23,420.00	1,040.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	1,550.00	3,790.00
TOTAL ROUTINE	649	3	269,020.00	141,450.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	81	0	95,610.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	81	0	95,610.00	0.00
TOTAL ACCOMODATIONS	730	3	364,630.00	141,450.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261,180.77	0.00
MED/SURG SUPPLY	355,006.27	59.32
LABORATORY-GENERAL	422,854.02	0.00
RADIOLOGY-DIAGNOSTIC	44,802.23	0.00
CT SCAN	91,857.40	10,656.80
PHYSICAL THERAPY	12,563.48	0.00
EKG/ECG	40,822.94	0.00
IV THERAPY	12,144.17	0.00
OPERATING ROOM	125,190.22	0.00
LABOR/DELIVERY ROOM	30,356.67	0.00
RESPIRATORY SERVICES	32,841.13	0.00
ANESTHESIA	69,415.12	0.00
GI SERVICES	2,794.69	0.00
EMERGENCY ROOM	140,395.89	0.00
RECOVERY ROOM	12,953.98	0.00
LABORATORY PATHOLOGIC	13,966.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	2,867.32	3,584.15
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,828.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	78,447.42	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,210.44	583.30
AUDIOLOGY	3,028.86	0.00
CARDIOLOGY	16,968.48	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	430.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	969.77	563.83

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,444.44	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40,182.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,831,523.62	15,447.40
TOTAL ACCOMODATIONS	364,630.00	141,450.00
TOTAL CHARGES	2,196,153.62	156,897.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,879.75	ADJUSTMENTS	0.00
COVERED CHARGES	23,859.75	CONTRACTUAL ALLOW	-150.06
NON-COVERD CHARGES	3,020.00	TOTAL MEDICAID LIAB	24,009.81
		LESS: COB	24,009.81
		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	11	0	3,850.00	3,020.00
ROUTINE NURSERY	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	11	0	3,850.00	3,020.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	3,850.00	3,020.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,537.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,854.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,911.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,553.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,420.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	527.90	0.00	INJECTABLE DRUGS	427.86	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	528.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,248.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,009.75	0.00
TOTAL ACCOMODATIONS	3,850.00	3,020.00
TOTAL CHARGES	23,859.75	3,020.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES	00/00/00	THROUGH 00/00/00
SERVICE DATES	10/01/10	THROUGH 09/30/11
ADMISSION DATES	00/00/00	THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,416,053.84	ADJUSTMENTS	117,664.95
COVERED CHARGES	3,181,096.23	CONTRACTUAL ALLOW	2,398,484.71
NON-COVERD CHARGES	234,957.61	TOTAL MEDICAID LIAB	782,611.52
		LESS: COB	12.02
		LESS: COPAYMENT	2,862.19
		REIMBURSEMENT	779,737.31
		ALL OTHER	699,508.88
		FEE SCHEDULE-LAB	78,714.86
		INJECTABLE DRUGS	1,513.57

TOTAL NUMBER OF CLAIMS 2,464

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,524.62	292.91
MED/SURG SUPPLY	321,404.03	2,505.57
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	217,976.25	2,835.76
CT SCAN	213,710.13	12,397.63
PHYSICAL THERAPY	8,420.26	954.78
EKG/ECG	83,127.54	522.60
IV THERAPY	56,465.78	2,357.55
OPERATING ROOM	176,811.01	15,179.60
LABOR/DELIVERY ROOM	72,558.35	556.97
RESPIRATORY SERVICES	8,957.77	655.73
ANESTHESIA	128,672.19	0.00
GI SERVICES	44,889.05	2,533.71
EMERGENCY ROOM	750,012.20	4,993.80
RECOVERY ROOM	32,796.51	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,137.83	1,108.15
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	34,826.20	528.44
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,417.42	2,750.64
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,177.12	1,851.98
AUDIOLOGY	0.00	0.00
CARDIOLOGY	23,877.73	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	49,667.92	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	70,909.37	4,849.60

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	44,965.81	4,191.92
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	609,937.39	160,147.01
MRI SERVICES	94,871.16	1,375.60
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,982.59	12,300.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,181,096.23	234,890.87
TOTAL ACCOMODATIONS	0.00	66.74
TOTAL CHARGES	3,181,096.23	234,957.61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,190.19	ADJUSTMENTS	0.00
COVERED CHARGES	41,061.33	CONTRACTUAL ALLOW	1,174.57
NON-COVERD CHARGES	8,128.86	TOTAL MEDICAID LIAB	39,886.76
		LESS: COB	39,844.76
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	724.31	14.68
MED/SURG SUPPLY	3,373.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,475.86	0.00
CT SCAN	1,136.36	860.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	984.28	984.28
LABOR/DELIVERY ROOM	3,008.60	0.00
RESPIRATORY SERVICES	170.69	0.00
ANESTHESIA	1,600.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,118.86	450.88
RECOVERY ROOM	446.12	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 SERVICE	1,207.28	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	1,144.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	430.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	510.51	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	505.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,914.34	4,001.81
MRI SERVICES	2,310.05	1,644.72
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	172.49
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	41,061.33	8,128.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,061.33	8,128.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	405,270.45	ADJUSTMENTS	1,029.85
COVERED CHARGES	384,790.15	CONTRACTUAL ALLOW	359,393.40
NON-COVERD CHARGES	20,480.30	TOTAL MEDICAID LIAB	25,396.75
		LESS: COB	0.00
		LESS: COPAYMENT	975.06
		REIMBURSEMENT	24,421.69

TOTAL NUMBER OF CLAIMS 454

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,193.87	0.00	OTHER LAB	2,528.20	406.70
MED/SURG SUPPLY	8,134.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,540.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,735.98	1,956.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,726.56	17,134.23
EKG/ECG	5,921.08	0.00	MRI SERVICES	3,050.24	0.00
IV THERAPY	5,669.15	293.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,001.04	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	589.09	30.78	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	242,456.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,221.47	479.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	827.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,059.17	179.38			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,135.53	0.00			

TOTAL ANCILLARY	384,790.15	20,480.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	384,790.15	20,480.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,339.34	ADJUSTMENTS	0.00
COVERED CHARGES	6,962.21	CONTRACTUAL ALLOW	2,457.43
NON-COVERD CHARGES	1,377.13	TOTAL MEDICAID LIAB	4,504.78
		LESS: COB	4,498.78
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	618.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,407.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	298.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,893.09	340.47
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	200.59	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	984.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	310.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,010.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	223.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	52.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,962.21	1,377.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,962.21	1,377.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,481.92	ADJUSTMENTS	0.00
COVERED CHARGES	16,481.92	CONTRACTUAL ALLOW	11,950.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,531.33
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	4,525.33

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191.36	0.00
MED/SURG SUPPLY	8,244.08	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	261.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,028.93	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,200.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	223.06	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	239.24	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	93.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,481.92	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,481.92	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
PO BOX 4309
EASTMAN,GA 31023-4309

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,960,083.30	ADJUSTMENTS	53,283.63
COVERED CHARGES	1,931,926.55	CONTRACTUAL ALLOW	1,045,874.64
NON-COVERD CHARGES	28,156.75	TOTAL MEDICAID LIAB	886,051.91
		LESS: COB	11,510.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	874,541.69

TOTAL NUMBER OF ADMISSIONS 153

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	321	2	130,005.00	4,865.00
ROUTINE NURSERY	21	0	5,460.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	342	2	135,465.00	4,865.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	174	8	149,025.00	6,600.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	174	8	149,025.00	6,600.00
TOTAL ACCOMODATIONS	516	10	284,490.00	11,465.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	579,921.77	1,630.50
MED/SURG SUPPLY	161,010.48	0.00
LABORATORY-GENERAL	260,645.75	0.00
RADIOLOGY-DIAGNOSTIC	32,500.25	0.00
CT SCAN	100,023.50	412.00
PHYSICAL THERAPY	2,605.00	0.00
EKG/ECG	35,650.50	0.00
IV THERAPY	477.75	0.00
OPERATING ROOM	165,742.25	0.00
LABOR/DELIVERY ROOM	3,883.50	8,896.25
RESPIRATORY SERVICES	97,141.00	0.00
ANESTHESIA	20,394.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,327.75	0.00
RECOVERY ROOM	25,917.50	0.00
LABORATORY PATHOLOGIC	3,883.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	617.25	0.00
SPEECH PATHOLOGY	849.00	0.00
RENAL DIALYSIS	795.75	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 SERVICE	7,987.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	36,502.25	398.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,976.00	0.00
AUDIOLOGY	425.00	0.00
CARDIOLOGY	19,200.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,687.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,766.50	5,355.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,551.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	16,232.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,721.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,647,436.55	16,691.75
TOTAL ACCOMODATIONS	284,490.00	11,465.00
TOTAL CHARGES	1,931,926.55	28,156.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/10	THROUGH	07/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,650,767.36	ADJUSTMENTS	53,930.21
COVERED CHARGES	1,422,318.73	CONTRACTUAL ALLOW	999,513.94
NON-COVERD CHARGES	228,448.63	TOTAL MEDICAID LIAB	422,804.79
		LESS: COB	115.75
		LESS: COPAYMENT	2,487.00
		REIMBURSEMENT	420,202.04
		ALL OTHER	369,051.24
		FEE SCHEDULE-LAB	51,134.56
		INJECTABLE DRUGS	16.24
		TOTAL NUMBER OF CLAIMS	1,826

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,035.50	4,333.75
MED/SURG SUPPLY	92,401.66	13,958.38
LABORATORY-GENERAL	0.00	26.75
RADIOLOGY-DIAGNOSTIC	92,526.50	4,751.00
CT SCAN	162,627.25	42,212.00
PHYSICAL THERAPY	7,878.00	1,861.75
EKG/ECG	28,629.00	751.00
IV THERAPY	1,141.75	0.00
OPERATING ROOM	87,707.00	67,378.75
LABOR/DELIVERY ROOM	7,006.00	0.00
RESPIRATORY SERVICES	10,315.75	6,070.50
ANESTHESIA	22,669.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	124,736.25	1,157.00
RECOVERY ROOM	34,556.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	670.75	128.00
SPEECH PATHOLOGY	1,412.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,406.97	135.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	56,536.75	414.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,345.00	646.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,842.00	5,827.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,404.25	1,273.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	49,214.25	350.25
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	50,484.75	1,650.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	18,725.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	328,297.35	71,727.50
MRI SERVICES	61,110.00	0.00
PROFESSIONAL FEES	0.00	780.25
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	639.00	3,014.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,422,318.73	228,448.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,422,318.73	228,448.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,147.78	ADJUSTMENTS	0.00
COVERED CHARGES	6,756.53	CONTRACTUAL ALLOW	4,177.64
NON-COVERD CHARGES	1,391.25	TOTAL MEDICAID LIAB	2,578.89
		LESS: COB	2,563.89
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	150.00
MED/SURG SUPPLY	161.52	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	276.25	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	462.00	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	139.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	531.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,087.50	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/OBSERV. RM	212.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	557.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,195.51	1,168.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	72.50

TOTAL ANCILLARY	6,756.53	1,391.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,756.53	1,391.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
5510	4010286001509	09/23/10 - 09/23/10	10/18/10	0.00	72.50	0.00	97.43	0.00
TOTAL				0.00	72.50	0.00	97.43	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	199,412.00	ADJUSTMENTS	1,450.38
COVERED CHARGES	176,281.75	CONTRACTUAL ALLOW	157,573.79
NON-COVERD CHARGES	23,130.25	TOTAL MEDICAID LIAB	18,707.96
		LESS: COB	0.00
		LESS: COPAYMENT	663.02
		REIMBURSEMENT	18,044.94

TOTAL NUMBER OF CLAIMS 335

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,947.80	203.00
MED/SURG SUPPLY	4,304.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,263.00	0.00
CT SCAN	21,103.25	10,174.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,444.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30.00	640.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	53,345.25	172.75
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	11.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,287.25	132.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	229.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,087.50	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/OBSERV. RM	9,939.50	426.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	743.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,070.50	10,007.75
MRI SERVICES	4,031.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,187.20	631.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	176,281.75	23,130.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	176,281.75	23,130.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	964.64	ADJUSTMENTS	0.00
COVERED CHARGES	884.64	CONTRACTUAL ALLOW	439.70
NON-COVERD CHARGES	80.00	TOTAL MEDICAID LIAB	444.94
		LESS: COB	444.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	158.75	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	884.64	80.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	884.64	80.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,898.99	ADJUSTMENTS	0.00
COVERED CHARGES	32,182.49	CONTRACTUAL ALLOW	22,679.11
NON-COVERD CHARGES	716.50	TOTAL MEDICAID LIAB	9,503.38
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	9,494.38

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,433.50	0.00
MED/SURG SUPPLY	4,846.49	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	571.25	265.25
CT SCAN	1,910.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	14,245.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	64.00
ANESTHESIA	1,859.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	172.75	0.00
RECOVERY ROOM	2,009.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	922.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,212.00	347.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	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 LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	32,182.49	716.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,182.49	716.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,956,070.02	ADJUSTMENTS	938,868.94
COVERED CHARGES	16,633,021.57	CONTRACTUAL ALLOW	11,595,415.39
NON-COVERD CHARGES	323,048.45	TOTAL MEDICAID LIAB	5,037,606.18
		LESS: COB	45,504.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,992,101.72

TOTAL NUMBER OF ADMISSIONS 729

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,225	0	1,146,600.00	112,788.00
ROUTINE NURSERY	208	0	74,894.00	702.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	1,433	4	1,221,494.00	113,490.00
SPECIAL CARE SERVICES				
CCU	1,119	0	1,600,642.00	0.00
ICU	283	0	649,429.00	0.00
NICU	1	0	900.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,403	0	2,250,971.00	0.00
TOTAL ACCOMODATIONS	2,836	4	3,472,465.00	113,490.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,402,467.39	2,767.75
MED/SURG SUPPLY	533,069.00	1,283.00
LABORATORY-GENERAL	2,531,022.48	0.00
RADIOLOGY-DIAGNOSTIC	439,323.00	0.00
CT SCAN	1,067,848.00	0.00
PHYSICAL THERAPY	42,009.00	0.00
EKG/ECG	124,820.00	0.00
IV THERAPY	126,904.00	13,619.00
OPERATING ROOM	684,753.00	0.00
LABOR/DELIVERY ROOM	612,382.00	0.00
RESPIRATORY SERVICES	1,329,264.00	587.00
ANESTHESIA	162,255.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	973,870.00	3,405.00
RECOVERY ROOM	105,182.00	0.00
LABORATORY PATHOLOGIC	57,822.60	425.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	685.00	0.00
SPEECH PATHOLOGY	13,907.00	0.00
RENAL DIALYSIS	319,854.00	158,568.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,740.00	809.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	112,278.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	167,277.00	11,771.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	234,637.00	11,424.00
AUDIOLOGY	48,212.00	0.00
CARDIOLOGY	482,128.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	67,767.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,223.85	1,887.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	129,299.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,383.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,996.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	353,376.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,798.25	16.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,160,556.57	209,558.45
TOTAL ACCOMODATIONS	3,472,465.00	113,490.00
TOTAL CHARGES	16,633,021.57	323,048.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,540.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,108.00	CONTRACTUAL ALLOW	9,441.28
NON-COVERD CHARGES	432.00	TOTAL MEDICAID LIAB	9,666.72
		LESS: COB	9,666.72
		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	4	0	3,744.00	312.00
ROUTINE NURSERY	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	3,744.00	312.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	3,744.00	312.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,102.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,286.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	712.00	0.00	EDUCATION & TRAINING	120.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,184.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,397.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,224.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,050.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	280.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,364.00	120.00
TOTAL ACCOMODATIONS	3,744.00	312.00
TOTAL CHARGES	19,108.00	432.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,315,930.82	ADJUSTMENTS	405,152.97
COVERED CHARGES	8,653,257.32	CONTRACTUAL ALLOW	6,936,445.72
NON-COVERD CHARGES	662,673.50	TOTAL MEDICAID LIAB	1,716,811.60
		LESS: COB	4,984.95
		LESS: COPAYMENT	3,210.00
		REIMBURSEMENT	1,708,616.65
		ALL OTHER	1,574,025.58
		FEE SCHEDULE-LAB	103,994.78
		INJECTABLE DRUGS	30,596.29

TOTAL NUMBER OF CLAIMS 4,420

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331,973.25	432.00
MED/SURG SUPPLY	154,891.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	624,377.00	11,563.00
CT SCAN	1,273,692.00	204,013.00
PHYSICAL THERAPY	13,831.00	7,691.00
EKG/ECG	113,208.00	0.00
IV THERAPY	28,699.00	480.00
OPERATING ROOM	394,572.00	78,915.00
LABOR/DELIVERY ROOM	101,091.00	0.00
RESPIRATORY SERVICES	66,372.00	23,085.00
ANESTHESIA	140,468.00	10,323.00
GI SERVICES	1,529.00	0.00
EMERGENCY ROOM	2,654,424.00	13,989.00
RECOVERY ROOM	121,190.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,251.00	0.00
OCCUPATIONAL THERAPY	2,182.00	0.00
SPEECH PATHOLOGY	0.00	595.00
RENAL DIALYSIS	0.00	3,337.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,255.00	2,829.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	305,612.00	31,959.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,315.00	3,632.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	156,126.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	152,843.00	14,304.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	55,568.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	110,244.66	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	84,901.00	4,277.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,410,858.91	172,257.00
MRI SERVICES	174,376.00	39,344.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	355.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	151,052.50	39,648.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,653,257.32	662,673.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,653,257.32	662,673.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,405.70	ADJUSTMENTS	0.00
COVERED CHARGES	158,988.95	CONTRACTUAL ALLOW	91,368.98
NON-COVERD CHARGES	11,416.75	TOTAL MEDICAID LIAB	67,619.97
		LESS: COB	67,561.18
		LESS: COPAYMENT	58.79
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,551.00	8.00
MED/SURG SUPPLY	1,613.00	0.00
LABORATORY-GENERAL	0.00	140.00
RADIOLOGY-DIAGNOSTIC	16,158.00	635.00
CT SCAN	10,965.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,586.00	0.00
IV THERAPY	286.00	0.00
OPERATING ROOM	7,200.00	0.00
LABOR/DELIVERY ROOM	11,409.00	0.00
RESPIRATORY SERVICES	3,827.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	52,232.00	1,923.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	468.00	60.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,724.00	2,649.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,448.00	760.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,197.95	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,803.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,807.00	4,395.00
MRI SERVICES	3,914.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	800.00	846.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	158,988.95	11,416.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	158,988.95	11,416.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	677,935.08	ADJUSTMENTS	5,964.40
COVERED CHARGES	656,650.68	CONTRACTUAL ALLOW	619,859.86
NON-COVERD CHARGES	21,284.40	TOTAL MEDICAID LIAB	36,790.82
		LESS: COB	0.00
		LESS: COPAYMENT	1,137.00
		REIMBURSEMENT	35,653.82

TOTAL NUMBER OF CLAIMS 660

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,106.00	0.00
MED/SURG SUPPLY	1,330.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,833.00	0.00
CT SCAN	36,142.00	5,122.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,632.00	0.00
IV THERAPY	462.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	380.00	0.00
RESPIRATORY SERVICES	4,215.00	942.00
ANESTHESIA	353.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	412,340.00	1,423.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	18,309.00	2,439.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	997.93	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,407.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	114,653.00	11,358.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	490.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	656,650.68	21,284.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	656,650.68	21,284.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,538.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,612.00	CONTRACTUAL ALLOW	12,680.74
NON-COVERD CHARGES	926.00	TOTAL MEDICAID LIAB	2,931.26
		LESS: COB	2,910.26
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	711.00	0.00	OTHER LAB	1,393.00	0.00
MED/SURG SUPPLY	142.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	351.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,345.00	363.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,730.00	202.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	191.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	749.00	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,612.00	926.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,612.00	926.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	527,843.06	ADJUSTMENTS	15,409.56
COVERED CHARGES	512,797.31	CONTRACTUAL ALLOW	437,715.55
NON-COVERD CHARGES	15,045.75	TOTAL MEDICAID LIAB	75,081.76
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	74,925.76
		TOTAL NUMBER OF CLAIMS	15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,927.75	0.00
MED/SURG SUPPLY	3,088.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,781.00	0.00
CT SCAN	7,781.00	2,244.00
PHYSICAL THERAPY	0.00	380.00
EKG/ECG	1,120.00	0.00
IV THERAPY	9,962.00	0.00
OPERATING ROOM	0.00	3,533.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	362.00	0.00
ANESTHESIA	1,837.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,389.00	192.00
RECOVERY ROOM	1,156.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	15,668.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,803.00	60.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	22,254.00	0.00
OTHER IMAGING SERVICE	693.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,340.00	704.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,443.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,379.00	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/OBSERV. RM	11,754.31	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,393.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,559.00	2,393.00
MRI SERVICES	3,295.00	3,322.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	367,422.25	2,217.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	512,797.31	15,045.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	512,797.31	15,045.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR DOUGLAS HOSPITAL
PO BOX 406158
ATLANTA,GA 30384-6158

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	175,184.40	ADJUSTMENTS	5,508.59
COVERED CHARGES	173,450.40	CONTRACTUAL ALLOW	69,673.86
NON-COVERD CHARGES	1,734.00	TOTAL MEDICAID LIAB	103,776.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	103,776.54

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	68	0	34,632.00	500.00
ROUTINE NURSERY	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	68	0	34,632.00	500.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	68	0	34,632.00	500.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,684.40	0.00	OTHER LAB	440.00	0.00
MED/SURG SUPPLY	9,360.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,317.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,131.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,169.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,564.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	910.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,444.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,245.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,308.00	1,234.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	775.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	754.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	440.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	412.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,865.00	0.00			

TOTAL ANCILLARY	138,818.40	1,234.00
TOTAL ACCOMODATIONS	34,632.00	500.00
TOTAL CHARGES	173,450.40	1,734.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	738,243.70	ADJUSTMENTS	27,036.16
COVERED CHARGES	649,918.60	CONTRACTUAL ALLOW	418,717.38
NON-COVERD CHARGES	88,325.10	TOTAL MEDICAID LIAB	231,201.22
		LESS: COB	0.00
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	230,592.22
		ALL OTHER	208,939.20
		FEE SCHEDULE-LAB	17,846.17
		INJECTABLE DRUGS	3,806.85

TOTAL NUMBER OF CLAIMS 800

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,782.60	807.00	OTHER LAB	2,293.00	440.00
MED/SURG SUPPLY	14,534.00	301.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,083.00	179.00	OTHER THERAPEUTIC SVC	0.00	364.00
CT SCAN	66,292.00	29,385.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	594.00	320.00	FEE SCHEDULE LAB	205,117.00	37,514.10
EKG/ECG	5,720.00	0.00	MRI SERVICES	4,698.00	0.00
IV THERAPY	1,286.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,194.00	7,680.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	231,165.00	1,461.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,325.00	9,692.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	182.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	11,470.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,365.00	0.00			

TOTAL ANCILLARY	649,918.60	88,325.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	649,918.60	88,325.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
4609	2211194008953	01/17/11 - 01/17/11	07/18/11	0.00	3.00	0.00	0.00	0.00
325	2211195004641	01/20/11 - 01/20/11	07/18/11	0.00	179.00	0.00	0.00	0.00
TOTAL				0.00	182.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	233.00	ADJUSTMENTS	0.00
COVERED CHARGES	214.00	CONTRACTUAL ALLOW	55.56
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	158.44
		LESS: COB	158.44
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	214.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	214.00	19.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	214.00	19.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,188.00	ADJUSTMENTS	679.00
COVERED CHARGES	66,755.00	CONTRACTUAL ALLOW	60,855.00
NON-COVERD CHARGES	2,433.00	TOTAL MEDICAID LIAB	5,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	5,717.00

TOTAL NUMBER OF CLAIMS 118

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,539.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	451.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,028.00	358.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,368.00	2,026.00
EKG/ECG	260.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,493.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,508.00	49.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	66,755.00	2,433.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,755.00	2,433.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,300.00	ADJUSTMENTS	0.00
COVERED CHARGES	22,670.00	CONTRACTUAL ALLOW	13,953.58
NON-COVERD CHARGES	5,630.00	TOTAL MEDICAID LIAB	8,716.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,716.42

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449.00	416.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	260.00	529.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,253.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361.00	1,702.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,281.00	1,168.00
EKG/ECG	130.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,019.00	750.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	442.00	910.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,131.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	229.00	155.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,115.00	0.00			

TOTAL ANCILLARY	22,670.00	5,630.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,670.00	5,630.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
PO BOX 1100
MAGEE,MS 39111-1100

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	140,428.00	ADJUSTMENTS	6,100.27
COVERED CHARGES	116,830.00	CONTRACTUAL ALLOW	77,083.53
NON-COVERD CHARGES	23,598.00	TOTAL MEDICAID LIAB	39,746.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,746.47

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	18	0	11,250.00	23,598.00
ROUTINE NURSERY	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	11,250.00	23,598.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	18	0	11,250.00	23,598.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,002.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37,543.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,937.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,372.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,698.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	963.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,946.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,050.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,864.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,415.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	971.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	708.00	0.00	INJECTABLE DRUGS	931.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,680.00	0.00			

TOTAL ANCILLARY	105,580.00	0.00
TOTAL ACCOMODATIONS	11,250.00	23,598.00
TOTAL CHARGES	116,830.00	23,598.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,214,340.03	ADJUSTMENTS	41,262.67
COVERED CHARGES	1,106,059.03	CONTRACTUAL ALLOW	671,014.79
NON-COVERD CHARGES	108,281.00	TOTAL MEDICAID LIAB	435,044.24
		LESS: COB	7,853.23
		LESS: COPAYMENT	1,377.00
		REIMBURSEMENT	425,814.01
		ALL OTHER	397,001.73
		FEE SCHEDULE-LAB	26,419.18
		INJECTABLE DRUGS	2,393.10

TOTAL NUMBER OF CLAIMS 1,150

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,462.16	0.00
MED/SURG SUPPLY	46,260.87	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	93,552.00	2,921.00
CT SCAN	112,855.00	49,223.00
PHYSICAL THERAPY	210.00	210.00
EKG/ECG	21,463.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,192.00	8,331.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,010.00	95.00
ANESTHESIA	8,960.00	667.00
GI SERVICES	28,124.00	1,529.00
EMERGENCY ROOM	359,760.00	0.00
RECOVERY ROOM	11,565.00	324.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	201.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	527.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	38,492.00	231.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,110.00	840.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,662.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,794.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,739.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	231,287.00	43,269.00
MRI SERVICES	46,670.00	0.00
PROFESSIONAL FEES	0.00	589.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,163.00	13.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	39.00

TOTAL ANCILLARY	1,106,059.03	108,281.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,106,059.03	108,281.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
6370	2211118003815	11/18/10 - 11/18/10	05/02/11	0.00	39.00	0.00	0.00	0.00
TOTAL				0.00	39.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,818.25	ADJUSTMENTS	0.00
COVERED CHARGES	7,055.25	CONTRACTUAL ALLOW	4,393.05
NON-COVERD CHARGES	1,763.00	TOTAL MEDICAID LIAB	2,662.20
		LESS: COB	2,656.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53.00	0.00
MED/SURG SUPPLY	211.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,048.00	0.00
CT SCAN	0.00	1,598.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	213.00	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	2,927.00	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 SERVICE	559.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,982.00	165.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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 LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,055.25	1,763.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,055.25	1,763.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	94,510.00	ADJUSTMENTS	44.00
COVERED CHARGES	91,729.00	CONTRACTUAL ALLOW	86,479.00
NON-COVERD CHARGES	2,781.00	TOTAL MEDICAID LIAB	5,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	147.00
		REIMBURSEMENT	5,103.00

TOTAL NUMBER OF CLAIMS 105

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,937.00	0.00
MED/SURG SUPPLY	902.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,452.00	0.00
CT SCAN	0.00	1,598.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	213.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	528.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	69,440.00	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 SERVICE	604.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,083.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,151.00	1,183.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	91,729.00	2,781.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,729.00	2,781.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,934.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,934.00	CONTRACTUAL ALLOW	892.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,041.64
		LESS: COB	1,041.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	539.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,325.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,934.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,934.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,556.00	ADJUSTMENTS	4,504.63
COVERED CHARGES	46,142.00	CONTRACTUAL ALLOW	28,123.48
NON-COVERD CHARGES	11,414.00	TOTAL MEDICAID LIAB	18,018.52
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	18,015.52

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,987.00	0.00
MED/SURG SUPPLY	8,554.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	724.00	0.00
CT SCAN	7,670.00	7,384.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,586.00	1,514.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,632.00	667.00
GI SERVICES	2,747.00	1,274.00
EMERGENCY ROOM	2,573.00	0.00
RECOVERY ROOM	2,505.00	324.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,632.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,405.00	251.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	127.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	46,142.00	11,414.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,142.00	11,414.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
PO BOX 386
SPRINGFIELD,GA 31329-0386

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	778,059.97	ADJUSTMENTS	94,759.49
COVERED CHARGES	768,088.97	CONTRACTUAL ALLOW	391,377.21
NON-COVERD CHARGES	9,971.00	TOTAL MEDICAID LIAB	376,711.76
		LESS: COB	2,551.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	374,160.17

TOTAL NUMBER OF ADMISSIONS 56

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	213	2	108,204.00	9,415.00
ROUTINE NURSERY	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	213	2	108,204.00	9,415.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	35	0	42,175.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	35	0	42,175.00	0.00
TOTAL ACCOMODATIONS	248	2	150,379.00	9,415.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,777.36	0.00	OTHER LAB	6,360.00	0.00
MED/SURG SUPPLY	51,731.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	128,826.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,426.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,865.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,361.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,536.00	0.00	MRI SERVICES	1,878.00	0.00
IV THERAPY	12,284.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	100,020.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,602.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,134.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,958.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,135.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,026.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,724.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,605.00	556.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,566.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,894.50	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	617,709.97	556.00
TOTAL ACCOMODATIONS	150,379.00	9,415.00
TOTAL CHARGES	768,088.97	9,971.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,427,019.13	ADJUSTMENTS	59,292.86
COVERED CHARGES	1,190,892.03	CONTRACTUAL ALLOW	866,656.49
NON-COVERD CHARGES	236,127.10	TOTAL MEDICAID LIAB	324,235.54
		LESS: COB	0.00
		LESS: COPAYMENT	1,431.00
		REIMBURSEMENT	322,804.54
		ALL OTHER	295,928.23
		FEE SCHEDULE-LAB	26,876.31
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,163

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,119.53	51,066.60
MED/SURG SUPPLY	26,151.00	21.50
LABORATORY-GENERAL	0.00	2,325.00
RADIOLOGY-DIAGNOSTIC	123,164.00	3,893.00
CT SCAN	111,570.00	67,013.00
PHYSICAL THERAPY	4,668.00	1,566.00
EKG/ECG	20,277.00	822.00
IV THERAPY	53,799.00	1,071.00
OPERATING ROOM	58,860.00	51,800.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,909.00	0.00
ANESTHESIA	8,666.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	261,451.00	4,254.00
RECOVERY ROOM	12,098.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	312.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	35,163.00	1,118.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,558.00	1,112.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,796.00	439.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,894.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	45,750.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	20,206.00	895.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,493.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	132.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	276,499.00	42,267.00
MRI SERVICES	34,668.00	642.00
PROFESSIONAL FEES	0.00	526.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,984.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,190,892.03	236,127.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,190,892.03	236,127.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,029.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,029.00	CONTRACTUAL ALLOW	549.86
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,479.14
		LESS: COB	1,479.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	645.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	427.00	0.00
EKG/ECG	137.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	820.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,029.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,029.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,499.79	ADJUSTMENTS	1,438.38
COVERED CHARGES	82,891.26	CONTRACTUAL ALLOW	75,615.75
NON-COVERD CHARGES	3,608.53	TOTAL MEDICAID LIAB	7,275.51
		LESS: COB	730.53
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	6,310.98

TOTAL NUMBER OF CLAIMS 117

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,123.46	2,440.53	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	108.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,443.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,151.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,364.00	740.00
EKG/ECG	685.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,810.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	861.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,345.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	428.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	82,891.26	3,608.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,891.26	3,608.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,096.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,651.50	CONTRACTUAL ALLOW	20,225.80
NON-COVERD CHARGES	4,445.00	TOTAL MEDICAID LIAB	9,425.70
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	9,413.70

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,233.50	2,054.00
MED/SURG SUPPLY	4,142.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	278.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	274.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,420.00	1,000.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,396.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	790.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	670.00	839.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	29,651.50	4,445.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,651.50	4,445.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,756,512.22	ADJUSTMENTS	109,028.29
COVERED CHARGES	2,723,763.22	CONTRACTUAL ALLOW	1,364,783.75
NON-COVERD CHARGES	32,749.00	TOTAL MEDICAID LIAB	1,358,979.47
		LESS: COB	14,431.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,344,547.61

TOTAL NUMBER OF ADMISSIONS 270

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	754	1	372,712.00	13,770.00
ROUTINE NURSERY	57	0	28,512.00	4,686.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	811	1	401,224.00	18,456.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	91	0	100,887.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	91	0	100,887.00	0.00
TOTAL ACCOMODATIONS	902	1	502,111.00	18,456.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	827,596.72	0.00
MED/SURG SUPPLY	193,513.50	70.00
LABORATORY-GENERAL	470,254.00	129.00
RADIOLOGY-DIAGNOSTIC	60,991.00	0.00
CT SCAN	129,343.00	0.00
PHYSICAL THERAPY	7,632.00	0.00
EKG/ECG	27,219.00	0.00
IV THERAPY	8,462.00	0.00
OPERATING ROOM	46,599.00	0.00
LABOR/DELIVERY ROOM	20,080.00	0.00
RESPIRATORY SERVICES	199,985.00	0.00
ANESTHESIA	1,058.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	127,262.00	0.00
RECOVERY ROOM	13,536.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,214.00	0.00
SPEECH PATHOLOGY	473.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,074.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,999.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,182.00	718.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,062.00	0.00
AUDIOLOGY	7,254.00	0.00
CARDIOLOGY	20,573.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,504.00	4,648.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,063.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,797.00	0.00
PROFESSIONAL FEES	0.00	6,654.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,221,652.22	14,293.00
TOTAL ACCOMODATIONS	502,111.00	18,456.00
TOTAL CHARGES	2,723,763.22	32,749.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,516.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,250.00	CONTRACTUAL ALLOW	11,215.04
NON-COVERD CHARGES	1,266.00	TOTAL MEDICAID LIAB	17,034.96
		LESS: COB	17,034.96
		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	4	0	1,988.00	0.00
ROUTINE NURSERY	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	1,988.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	1,102.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	1,102.00	0.00
TOTAL ACCOMODATIONS	5	0	3,090.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,939.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,063.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,192.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	441.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	567.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	294.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,086.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,544.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,034.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,266.00			

TOTAL ANCILLARY	25,160.00	1,266.00
TOTAL ACCOMODATIONS	3,090.00	0.00
TOTAL CHARGES	28,250.00	1,266.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,862,603.50	ADJUSTMENTS	106,410.20
COVERED CHARGES	2,557,216.50	CONTRACTUAL ALLOW	1,979,805.54
NON-COVERD CHARGES	305,387.00	TOTAL MEDICAID LIAB	577,410.96
		LESS: COB	30.00
		LESS: COPAYMENT	2,421.00
		REIMBURSEMENT	574,959.96
		ALL OTHER	518,987.03
		FEE SCHEDULE-LAB	55,873.42
		INJECTABLE DRUGS	99.51
		TOTAL NUMBER OF CLAIMS	2,275

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,561.00	653.00
MED/SURG SUPPLY	145,166.00	2,067.00
LABORATORY-GENERAL	0.00	80.00
RADIOLOGY-DIAGNOSTIC	178,463.00	14,790.00
CT SCAN	297,933.00	49,007.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	39,922.00	375.00
IV THERAPY	50,788.00	2,232.00
OPERATING ROOM	99,858.00	13,533.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,721.00	134.00
ANESTHESIA	4,745.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	500,564.00	15,865.00
RECOVERY ROOM	24,298.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,694.50	1,025.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	111,594.00	1,997.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	546.00	359.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,225.00	446.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,802.00	1,564.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	22,031.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	60,579.00	27,559.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,375.00	2,296.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	615,941.00	165,522.00
MRI SERVICES	84,044.00	5,110.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	366.00	773.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,557,216.50	305,387.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,557,216.50	305,387.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,373.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,566.00	CONTRACTUAL ALLOW	2,146.85
NON-COVERD CHARGES	1,807.00	TOTAL MEDICAID LIAB	10,419.15
		LESS: COB	10,410.15
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	900.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	591.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	13.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,261.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,038.00	455.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	587.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,041.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,199.00	298.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	356.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	916.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,566.00	1,807.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,566.00	1,807.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	299,732.00	ADJUSTMENTS	3,339.28
COVERED CHARGES	285,671.00	CONTRACTUAL ALLOW	264,917.26
NON-COVERD CHARGES	14,061.00	TOTAL MEDICAID LIAB	20,753.74
		LESS: COB	0.00
		LESS: COPAYMENT	717.00
		REIMBURSEMENT	20,036.74

TOTAL NUMBER OF CLAIMS 371

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,174.00	341.00
MED/SURG SUPPLY	4,911.00	22.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,571.00	0.00
CT SCAN	12,321.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,647.00	0.00
IV THERAPY	4,996.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,222.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	140,742.00	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 SERVICE	2,538.00	983.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,020.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	574.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,898.00	12,141.00
MRI SERVICES	2,631.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	285,671.00	14,061.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	285,671.00	14,061.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,282.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,080.00	CONTRACTUAL ALLOW	5,295.49
NON-COVERD CHARGES	202.00	TOTAL MEDICAID LIAB	784.51
		LESS: COB	778.51
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	216.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	111.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	218.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,320.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,046.00	202.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	559.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,610.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,080.00	202.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,080.00	202.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,220.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,273.00	CONTRACTUAL ALLOW	14,449.36
NON-COVERD CHARGES	947.00	TOTAL MEDICAID LIAB	4,823.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,823.64

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,160.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	752.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	280.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,526.00	947.00
EKG/ECG	192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	147.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,216.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,273.00	947.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,273.00	947.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
PO BOX 7
SWAINSBORO,GA 30401-0007

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	100,887,214.54	ADJUSTMENTS	6,809,653.89
COVERED CHARGES	96,026,994.37	CONTRACTUAL ALLOW	60,795,910.60
NON-COVERD CHARGES	4,860,220.17	TOTAL MEDICAID LIAB	35,231,083.77
		LESS: COB	239,191.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,991,892.09

TOTAL NUMBER OF ADMISSIONS 1,799

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,734	35	8,586,400.00	92,140.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	9	0.00	0.00
TOTAL ROUTINE	7,734	44	8,586,400.00	92,140.00
SPECIAL CARE SERVICES				
CCU	462	0	1,762,127.30	0.00
ICU	5,264	4	14,557,822.30	15,220.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	637	0	1,121,863.60	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	2,224	0.00	3,301,958.60
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,363	2,228	17,441,813.20	3,317,178.60
TOTAL ACCOMODATIONS	14,097	2,272	26,028,213.20	3,409,318.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,768,141.12	30,364.23
MED/SURG SUPPLY	7,448,918.58	201,087.15
LABORATORY-GENERAL	10,357,856.35	105,070.15
RADIOLOGY-DIAGNOSTIC	1,870,089.00	2,716.00
CT SCAN	2,579,634.00	28,665.00
PHYSICAL THERAPY	1,358,277.00	5,634.00
EKG/ECG	224,131.00	560.00
IV THERAPY	14,060.00	1,265.00
OPERATING ROOM	7,838,504.00	56,771.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,891,135.40	43,448.00
ANESTHESIA	1,621,215.00	16,828.00
GI SERVICES	357,778.00	1,234.00
EMERGENCY ROOM	1,138,066.00	9,705.00
RECOVERY ROOM	468,489.00	3,150.00
LABORATORY PATHOLOGIC	656,695.00	1,046.00
RADIOLOGY THERAPEUTIC	27,458.75	1,952.00
OCCUPATIONAL THERAPY	1,385,748.00	4,346.00
SPEECH PATHOLOGY	597,505.00	10,661.00
RENAL DIALYSIS	543,890.00	82,830.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	18,285.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	218,920.00	212,860.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,115,978.50	2,856.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	90,015.00	71,502.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,778,527.00	10,536.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,132,221.00	0.00
ORGAN ACQUISITION	1,380,780.00	196,044.00
TREATMENT/OBSERV. RM	20,728.00	552.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	681,730.00	2,599.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,758,068.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	127,249.38
INJECTABLE DRUGS	8,655,937.47	204,129.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	2,001.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	13,240.00

TOTAL ANCILLARY	69,998,781.17	1,450,901.57
TOTAL ACCOMODATIONS	26,028,213.20	3,409,318.60
TOTAL CHARGES	96,026,994.37	4,860,220.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	9112009000781	01/18/11 - 01/18/11	01/16/12	0.00	0.00	0.00	1,676.29	0.00
618	2312017000205	02/03/11 - 02/25/11	03/12/12	0.00	2,390.00	0.00	0.00	0.00
614	2012208023080	06/13/11 - 06/16/11	07/30/12	0.00	5,425.00	0.00	0.00	0.00
614	2012222003320	01/22/11 - 02/10/11	08/13/12	0.00	5,425.00	0.00	0.00	0.00
TOTAL				0.00	13,240.00	0.00	1,676.29	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,935,518.62	ADJUSTMENTS	0.00
COVERED CHARGES	1,926,247.41	CONTRACTUAL ALLOW	134,168.67
NON-COVERD CHARGES	9,271.21	TOTAL MEDICAID LIAB	1,792,078.74
		LESS: COB	1,792,078.74
		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	179	0	198,540.00	150.00
ROUTINE NURSERY	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	179	0	198,540.00	150.00
SPECIAL CARE SERVICES				
CCU	30	0	114,150.00	0.00
ICU	65	0	148,155.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	9	0	15,840.00	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	104	0	278,145.00	0.00
TOTAL ACCOMODATIONS	283	0	476,685.00	150.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,931.05	3.50
MED/SURG SUPPLY	355,692.75	290.04
LABORATORY-GENERAL	174,652.50	0.00
RADIOLOGY-DIAGNOSTIC	26,690.00	0.00
CT SCAN	59,596.00	0.00
PHYSICAL THERAPY	12,756.00	0.00
EKG/ECG	3,360.00	0.00
IV THERAPY	645.00	0.00
OPERATING ROOM	167,365.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46,173.00	0.00
ANESTHESIA	30,231.00	0.00
GI SERVICES	4,872.00	0.00
EMERGENCY ROOM	23,881.00	0.00
RECOVERY ROOM	12,830.00	0.00
LABORATORY PATHOLOGIC	6,944.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,285.00	0.00
SPEECH PATHOLOGY	9,905.00	0.00
RENAL DIALYSIS	1,290.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	525.00	6,541.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,826.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,083.00	2,204.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,572.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	44,325.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	48.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,750.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	18,543.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	176,791.11	82.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,449,562.41	9,121.21
TOTAL ACCOMODATIONS	476,685.00	150.00
TOTAL CHARGES	1,926,247.41	9,271.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,661,158.85	ADJUSTMENTS	175,839.67
COVERED CHARGES	16,180,290.88	CONTRACTUAL ALLOW	11,665,221.34
NON-COVERD CHARGES	5,480,867.97	TOTAL MEDICAID LIAB	4,515,069.54
		LESS: COB	8,420.43
		LESS: COPAYMENT	12,966.46
		REIMBURSEMENT	4,493,682.65
		ALL OTHER	3,904,148.62
		FEE SCHEDULE-LAB	546,239.22
		INJECTABLE DRUGS	43,294.81

TOTAL NUMBER OF CLAIMS 8,970

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	888,012.89	4,748.23
MED/SURG SUPPLY	789,136.05	364,003.00
LABORATORY-GENERAL	0.00	870.00
RADIOLOGY-DIAGNOSTIC	576,642.00	86,414.00
CT SCAN	1,564,469.00	574,415.00
PHYSICAL THERAPY	113,151.00	30,375.00
EKG/ECG	95,312.00	1,514.00
IV THERAPY	2,645.00	0.00
OPERATING ROOM	941,729.00	642,778.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	76,164.00	3,424.00
ANESTHESIA	248,848.00	0.00
GI SERVICES	115,250.00	39,540.00
EMERGENCY ROOM	1,110,352.00	71,503.00
RECOVERY ROOM	170,174.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	504.00	432.00
OCCUPATIONAL THERAPY	74,087.00	34,386.00
SPEECH PATHOLOGY	47,258.00	22,667.00
RENAL DIALYSIS	0.00	15,480.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	402.00	1,564.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	639,469.00	500,094.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	28,985.00	1,488.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	224,992.00	186,143.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	376,175.00	526,166.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,382.00	548.00
ORGAN ACQUISITION	0.00	4,716.00
TREATMENT/OBSERV. RM	516,350.00	91,775.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	95,086.00	4,845.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	178.00	1,691.00
OTHER THERAPEUTIC SVC	0.00	125,928.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,067,861.00	1,270,935.60
MRI SERVICES	3,232,536.00	748,386.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,600.00
INJECTABLE DRUGS	170,140.94	122,399.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	40.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,180,290.88	5,480,867.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,180,290.88	5,480,867.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	859,680.94	ADJUSTMENTS	0.00
COVERED CHARGES	571,816.52	CONTRACTUAL ALLOW	-150,737.39
NON-COVERD CHARGES	287,864.42	TOTAL MEDICAID LIAB	722,553.91
		LESS: COB	722,138.51
		LESS: COPAYMENT	415.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	214

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,223.32	202.71
MED/SURG SUPPLY	42,668.00	87,805.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,808.00	696.00
CT SCAN	47,560.00	10,683.00
PHYSICAL THERAPY	1,564.00	2,974.00
EKG/ECG	2,912.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	23,908.00	67,722.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,553.00	0.00
ANESTHESIA	14,747.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	48,731.00	3,767.00
RECOVERY ROOM	9,240.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	424.00	0.00
SPEECH PATHOLOGY	354.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	68.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	26,576.00	13,082.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,118.00	3,236.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	32,919.00	19,838.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,060.00	0.00
ORGAN ACQUISITION	0.00	4,125.00
TREATMENT/OBSERV. RM	19,367.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,504.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	112,254.00	37,429.00
MRI SERVICES	129,163.00	23,602.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,044.00
INJECTABLE DRUGS	2,163.20	7,590.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	571,816.52	287,864.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	571,816.52	287,864.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	194,712.71	ADJUSTMENTS	482.46
COVERED CHARGES	174,825.01	CONTRACTUAL ALLOW	167,329.05
NON-COVERD CHARGES	19,887.70	TOTAL MEDICAID LIAB	7,495.96
		LESS: COB	0.00
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	7,114.96

TOTAL NUMBER OF CLAIMS 134

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,797.29	3.20
MED/SURG SUPPLY	2,292.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,563.00	223.00
CT SCAN	12,539.00	4,038.00
PHYSICAL THERAPY	0.00	742.00
EKG/ECG	2,912.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,395.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	70,023.00	651.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	781.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,086.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	548.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,558.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,430.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,093.00	7,917.30
MRI SERVICES	25,605.00	5,303.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	983.72	229.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	174,825.01	19,887.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	174,825.01	19,887.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,403.96	ADJUSTMENTS	0.00
COVERED CHARGES	3,403.96	CONTRACTUAL ALLOW	1,284.73
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,119.23
		LESS: COB	2,107.23
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	126.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	944.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,253.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,403.96	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,403.96	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,423,530.42	ADJUSTMENTS	24,875.08
COVERED CHARGES	2,787,471.35	CONTRACTUAL ALLOW	2,125,512.74
NON-COVERD CHARGES	636,059.07	TOTAL MEDICAID LIAB	661,958.61
		LESS: COB	0.00
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	661,412.61

TOTAL NUMBER OF CLAIMS 108

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112,151.61	246.25
MED/SURG SUPPLY	916,673.25	289,255.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	509,523.00	77,019.00
CT SCAN	6,621.00	6,021.00
PHYSICAL THERAPY	0.00	723.00
EKG/ECG	3,136.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	459,726.00	197,648.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,588.00	495.00
ANESTHESIA	74,804.00	0.00
GI SERVICES	8,935.00	0.00
EMERGENCY ROOM	3,219.00	93.00
RECOVERY ROOM	43,226.00	1,470.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,512.00	3,816.00
OCCUPATIONAL THERAPY	0.00	352.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,580.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,200.00	75.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,361.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	31,155.00	8,946.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	96,510.00	9,621.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,517.00	7,770.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,378.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	61,001.00	11,747.00
MRI SERVICES	374,439.00	10,083.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,795.49	8,098.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,787,471.35	636,059.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,787,471.35	636,059.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	272,986.91	ADJUSTMENTS	0.00
COVERED CHARGES	230,894.93	CONTRACTUAL ALLOW	-34,554.75
NON-COVERD CHARGES	42,091.98	TOTAL MEDICAID LIAB	265,449.68
		LESS: COB	265,419.68
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,176.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	143,582.00	269.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,751.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,754.00	209.00
EKG/ECG	0.00	0.00	MRI SERVICES	16,242.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,424.00	37,960.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,881.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,038.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24.03	3,653.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	230,894.93	42,091.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	230,894.93	42,091.98

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,415,226.56	ADJUSTMENTS	8,294,298.23
COVERED CHARGES	110,443,096.72	CONTRACTUAL ALLOW	74,397,008.44
NON-COVERD CHARGES	4,972,129.84	TOTAL MEDICAID LIAB	36,046,088.28
		LESS: COB	178,495.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,867,593.01

TOTAL NUMBER OF ADMISSIONS 2,978

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15,394	367	8,542,880.00	2,723,569.00
ROUTINE NURSERY	1,368	0	2,086,175.00	286,148.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	20	2.00	11.10
TOTAL ROUTINE	16,762	387	10,629,057.00	3,009,728.10
SPECIAL CARE SERVICES				
CCU	126	0	177,298.00	0.00
ICU	2,897	0	4,777,850.00	28,203.00
NICU	480	0	1,462,322.00	0.00
PED ICU	765	0	2,335,499.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	602	0	1,625,223.00	5,240.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,870	0	10,378,192.00	33,443.00
TOTAL ACCOMODATIONS	21,632	387	21,007,249.00	3,043,171.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,448,465.33	380,751.80
MED/SURG SUPPLY	16,817,974.98	253,442.03
LABORATORY-GENERAL	15,905,651.87	147,016.35
RADIOLOGY-DIAGNOSTIC	2,662,214.00	8,278.00
CT SCAN	2,463,326.00	448,106.00
PHYSICAL THERAPY	555,894.00	3,927.00
EKG/ECG	278,811.00	230.00
IV THERAPY	343,982.00	8,572.00
OPERATING ROOM	3,968,830.00	16,934.00
LABOR/DELIVERY ROOM	276,180.00	0.00
RESPIRATORY SERVICES	10,754,150.00	58,146.00
ANESTHESIA	683,318.00	3,756.00
GI SERVICES	444.00	0.00
EMERGENCY ROOM	2,479,370.00	1,768.00
RECOVERY ROOM	678,656.00	1,034.00
LABORATORY PATHOLOGIC	1,045,802.00	880.00
RADIOLOGY THERAPEUTIC	259,169.00	0.00
OCCUPATIONAL THERAPY	242,441.00	1,428.00
SPEECH PATHOLOGY	158,924.00	382.00
RENAL DIALYSIS	278,349.00	66,816.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	182.81	54,258.00
PSYCHIATRIC SERVICES	1,218.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	346,600.00	55,548.00
BLOOD	569.00	0.00
BLOOD STORAGE & PRO.	1,699,389.00	16,617.00
ONCOLOGY	59.00	0.00
NUCLEAR MEDICINE	214,852.00	62,040.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,004,258.00	2,887.00
AMBULATORY SURGERY	8,659.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,606,404.00	0.00
ORGAN ACQUISITION	224,670.00	0.00
TREATMENT/OBSERV. RM	198,542.04	19,757.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	321,879.00	86.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,675.00	112.00
OTHER THERAPEUTIC SVC	159,800.00	64.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	786,141.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	117,311.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	6,191.20
INJECTABLE DRUGS	5,556,997.69	46,478.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	142,438.00
NO CC/INVALID REV CODE	0.00	3,704.00

TOTAL ANCILLARY	89,435,847.72	1,928,958.74
TOTAL ACCOMODATIONS	21,007,249.00	3,043,171.10
TOTAL CHARGES	110,443,096.72	4,972,129.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	4010211005191	07/15/10 - 07/15/10	08/02/10	0.00	1,852.00	0.00	0.00	0.00
614	5211068003625	11/14/10 - 01/07/11	03/14/11	0.00	1,852.00	0.00	0.00	0.00
TOTAL				0.00	3,704.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,880,013.99	ADJUSTMENTS	0.00
COVERED CHARGES	2,793,164.99	CONTRACTUAL ALLOW	607,537.86
NON-COVERD CHARGES	86,849.00	TOTAL MEDICAID LIAB	2,185,627.13
		LESS: COB	2,185,627.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	353	11	197,894.00	68,615.00
ROUTINE NURSERY	6	0	3,182.00	4,150.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	359	11	201,076.00	72,765.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	92	0	148,929.00	0.00
NICU	1	0	2,969.00	0.00
PED ICU	19	0	59,437.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	112	0	211,335.00	0.00
TOTAL ACCOMODATIONS	471	11	412,411.00	72,765.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,367.69	0.00
MED/SURG SUPPLY	610,886.00	0.00
LABORATORY-GENERAL	294,706.20	0.00
RADIOLOGY-DIAGNOSTIC	56,486.00	0.00
CT SCAN	48,856.00	1,711.00
PHYSICAL THERAPY	8,358.00	0.00
EKG/ECG	3,817.00	0.00
IV THERAPY	5,356.00	0.00
OPERATING ROOM	99,534.00	0.00
LABOR/DELIVERY ROOM	15,744.00	0.00
RESPIRATORY SERVICES	318,476.00	0.00
ANESTHESIA	25,329.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,687.00	0.00
RECOVERY ROOM	19,631.00	0.00
LABORATORY PATHOLOGIC	15,242.00	0.00
RADIOLOGY THERAPEUTIC	8,299.00	0.00
OCCUPATIONAL THERAPY	6,177.00	0.00
SPEECH PATHOLOGY	2,550.00	0.00
RENAL DIALYSIS	1,712.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,964.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,042.00	3,804.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	59,686.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,058.00	3,607.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,107.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	141,843.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,468.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	217.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,871.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	998.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	88,367.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,380,753.99	14,084.00
TOTAL ACCOMODATIONS	412,411.00	72,765.00
TOTAL CHARGES	2,793,164.99	86,849.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,389,765.67	ADJUSTMENTS	2,343,267.31
COVERED CHARGES	37,189,160.58	CONTRACTUAL ALLOW	25,947,675.73
NON-COVERD CHARGES	5,200,605.09	TOTAL MEDICAID LIAB	11,241,484.85
		LESS: COB	31,230.24
		LESS: COPAYMENT	53,571.00
		REIMBURSEMENT	11,156,683.61
		ALL OTHER	9,531,268.61
		FEE SCHEDULE-LAB	895,594.57
		INJECTABLE DRUGS	729,820.43

TOTAL NUMBER OF CLAIMS 35,149

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,268,525.81	91,292.20
MED/SURG SUPPLY	2,410,320.00	639,215.00
LABORATORY-GENERAL	0.00	318.00
RADIOLOGY-DIAGNOSTIC	1,331,856.00	147,021.00
CT SCAN	1,708,651.00	154,165.00
PHYSICAL THERAPY	43,306.00	21,790.00
EKG/ECG	197,821.00	1,822.00
IV THERAPY	277,169.00	1,995.00
OPERATING ROOM	2,631,314.26	440,710.11
LABOR/DELIVERY ROOM	194,375.00	0.00
RESPIRATORY SERVICES	847,170.00	18,722.00
ANESTHESIA	520,324.00	393.00
GI SERVICES	49,853.42	0.00
EMERGENCY ROOM	3,171,775.00	13,716.00
RECOVERY ROOM	1,302,046.00	1,224.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,476,644.00	197,128.00
OCCUPATIONAL THERAPY	5,503.00	2,257.00
SPEECH PATHOLOGY	17,542.00	17,290.00
RENAL DIALYSIS	0.00	587.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,731,135.37	133,372.14
PSYCHIATRIC SERVICES	116,409.00	4,280.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,050,641.00	50,122.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	419,875.97	29,808.46
ONCOLOGY	23,479.00	1,563.00
NUCLEAR MEDICINE	373,853.00	54,654.00
AUDIOLOGY	1,495.00	1,989.80
CARDIOLOGY	615,963.30	377,477.40
AMBULATORY SURGERY	3,398.00	0.00
OSTEOPATHIC SERVICES	0.00	126.00
E E G	417,528.00	8,288.00
ORGAN ACQUISITION	0.00	11,847.00
TREATMENT/OBSERV. RM	390,167.00	28,584.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	551,771.40	15,726.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,253.00	2,753.00
OTHER THERAPEUTIC SVC	45,040.00	4,276.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,363,651.04	1,052,916.94
MRI SERVICES	1,085,117.00	56,837.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	34,228.00
CAST ROOM	2,711.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	599.00
INJECTABLE DRUGS	3,534,477.01	1,570,022.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	10.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	10,647.00
NO CC/INVALID REV CODE	0.00	833.00

TOTAL ANCILLARY	37,189,160.58	5,200,605.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,189,160.58	5,200,605.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	4010202033149	07/12/10 - 07/12/10	07/26/10	0.00	16.00	0.00	0.00	0.00
780	4010211060781	07/21/10 - 07/21/10	08/02/10	0.00	16.00	0.00	0.00	0.00
780	4010211060789	07/21/10 - 07/21/10	08/02/10	0.00	16.00	0.00	0.00	0.00
780	4410224000598	07/21/10 - 07/21/10	08/16/10	0.00	16.00	0.00	0.00	0.00
780	4410245100059	08/18/10 - 08/18/10	09/07/10	0.00	16.00	0.00	0.00	0.00
780	4410245100223	07/12/10 - 07/12/10	09/07/10	0.00	16.00	0.00	0.00	0.00
355	4410252000611	08/19/10 - 08/19/10	09/13/10	0.00	188.00	0.00	0.00	0.00
591	4410265000548	08/18/10 - 08/18/10	09/27/10	0.00	132.00	0.00	0.00	0.00
780	4010270071805	09/15/10 - 09/15/10	10/04/10	0.00	16.00	0.00	0.00	0.00
355	5911084000715	07/16/10 - 07/16/10	03/28/11	0.00	275.00	0.00	0.00	0.00
461	5911124001505	04/18/11 - 04/18/11	05/09/11	0.00	126.00	0.00	0.00	0.00
TOTAL				0.00	833.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,447,236.83	ADJUSTMENTS	0.00
COVERED CHARGES	1,198,292.89	CONTRACTUAL ALLOW	214,102.08
NON-COVERD CHARGES	248,943.94	TOTAL MEDICAID LIAB	984,190.81
		LESS: COB	983,645.21
		LESS: COPAYMENT	545.60
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,080

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,074.31	2,928.28
MED/SURG SUPPLY	94,575.00	5,443.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,933.00	6,576.00
CT SCAN	22,961.00	15,367.00
PHYSICAL THERAPY	261.00	0.00
EKG/ECG	5,132.00	0.00
IV THERAPY	20,052.00	1,080.00
OPERATING ROOM	111,512.37	43,221.66
LABOR/DELIVERY ROOM	15,199.00	0.00
RESPIRATORY SERVICES	8,859.00	261.00
ANESTHESIA	30,259.00	0.00
GI SERVICES	8,046.00	0.00
EMERGENCY ROOM	63,907.00	176.00
RECOVERY ROOM	74,391.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	21,020.00	0.00
OCCUPATIONAL THERAPY	2,180.00	0.00
SPEECH PATHOLOGY	565.00	277.00
RENAL DIALYSIS	0.00	553.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	59,616.00	1,232.81
PSYCHIATRIC SERVICES	2,326.00	496.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	25,567.00	3,261.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,091.00	9,212.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,336.00	8,631.00
AUDIOLOGY	69.00	0.00
CARDIOLOGY	13,760.00	449.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,458.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,964.00	225.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	32,167.00	526.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	224.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,568.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	269,474.31	36,822.00
MRI SERVICES	34,320.00	10,995.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	125,993.90	98,643.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,198,292.89	248,943.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,198,292.89	248,943.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,391,363.07	ADJUSTMENTS	1,707.00
COVERED CHARGES	1,342,593.44	CONTRACTUAL ALLOW	1,243,893.44
NON-COVERD CHARGES	48,769.63	TOTAL MEDICAID LIAB	98,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	3,444.00
		REIMBURSEMENT	95,256.00
		TOTAL NUMBER OF CLAIMS	1,974

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,492.38	3,129.54
MED/SURG SUPPLY	22,406.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,703.00	198.00
CT SCAN	74,052.00	2,765.00
PHYSICAL THERAPY	0.00	261.00
EKG/ECG	8,286.00	0.00
IV THERAPY	30,683.00	60.00
OPERATING ROOM	19,200.00	2,424.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,406.00	50.00
ANESTHESIA	4,675.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	792,744.00	1,156.00
RECOVERY ROOM	11,271.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	150.00
SPEECH PATHOLOGY	0.00	261.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,174.00	3,494.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,617.00	3,499.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,282.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	631.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	42.00
E E G	1,690.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	666.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,292.00	590.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	199,964.80	21,486.00
MRI SERVICES	6,588.00	4,325.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,770.26	4,879.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,342,593.44	48,769.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,342,593.44	48,769.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,491.56	ADJUSTMENTS	0.00
COVERED CHARGES	42,776.56	CONTRACTUAL ALLOW	12,374.08
NON-COVERD CHARGES	9,715.00	TOTAL MEDICAID LIAB	30,402.48
		LESS: COB	30,375.48
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,612.56	600.00
MED/SURG SUPPLY	1,125.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,239.00	246.00
CT SCAN	4,482.00	5,846.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	346.00	0.00
IV THERAPY	821.00	0.00
OPERATING ROOM	1,159.00	835.00
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	20,639.00	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	212.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	177.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	652.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,964.00	1,514.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	22.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	42,776.56	9,715.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,776.56	9,715.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,293,319.24	ADJUSTMENTS	439,664.05
COVERED CHARGES	6,221,894.51	CONTRACTUAL ALLOW	5,119,316.12
NON-COVERD CHARGES	1,071,424.73	TOTAL MEDICAID LIAB	1,102,578.39
		LESS: COB	0.00
		LESS: COPAYMENT	1,742.96
		REIMBURSEMENT	1,100,835.43

TOTAL NUMBER OF CLAIMS 203

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282,280.84	5,523.08
MED/SURG SUPPLY	2,153,578.00	677,500.00
LABORATORY-GENERAL	0.00	292.00
RADIOLOGY-DIAGNOSTIC	104,933.80	17,049.80
CT SCAN	40,976.00	9,803.00
PHYSICAL THERAPY	0.00	4,799.00
EKG/ECG	4,308.00	0.00
IV THERAPY	4,848.00	0.00
OPERATING ROOM	664,706.37	59,844.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	48,687.00	0.00
ANESTHESIA	77,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,963.00	246.00
RECOVERY ROOM	98,248.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,143,839.00	11,640.00
OCCUPATIONAL THERAPY	0.00	940.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,348.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,466.00	15,399.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,999.00	1,038.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,977.00	0.00
ONCOLOGY	5,025.00	0.00
NUCLEAR MEDICINE	11,687.00	1,224.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	660,753.91	87,300.59
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/OBSERV. RM	14,031.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	741.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	123,250.00	28,266.30
MRI SERVICES	2,211.00	9,468.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	735,336.59	135,515.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	3,228.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,221,894.51	1,071,424.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,221,894.51	1,071,424.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,540.19	ADJUSTMENTS	0.00
COVERED CHARGES	74,331.71	CONTRACTUAL ALLOW	14,592.61
NON-COVERD CHARGES	1,208.48	TOTAL MEDICAID LIAB	59,739.10
		LESS: COB	59,736.10
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,352.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,818.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	908.00	284.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	342.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,690.60	924.48
RADIOLOGY THERAPEUTIC	813.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,408.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,331.71	1,208.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,331.71	1,208.48

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,319,479.79	ADJUSTMENTS	39,309.22
COVERED CHARGES	1,255,609.79	CONTRACTUAL ALLOW	784,320.44
NON-COVERD CHARGES	63,870.00	TOTAL MEDICAID LIAB	471,289.35
		LESS: COB	31,453.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	439,835.75

TOTAL NUMBER OF ADMISSIONS 74

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,192	0	169,840.00	57,560.00
ROUTINE NURSERY	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	1,192	0	169,840.00	57,560.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	38	0	42,560.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	38	0	42,560.00	0.00
TOTAL ACCOMODATIONS	1,230	0	212,400.00	57,560.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,603.70	0.00
MED/SURG SUPPLY	121,205.34	100.00
LABORATORY-GENERAL	307,295.00	0.00
RADIOLOGY-DIAGNOSTIC	40,875.00	0.00
CT SCAN	86,655.00	4,550.00
PHYSICAL THERAPY	3,310.00	0.00
EKG/ECG	5,850.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	6,730.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	51,470.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,220.00	0.00
EMERGENCY ROOM	56,695.00	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	660.00	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 SERVICE	6,140.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	34,860.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,285.00	115.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,790.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,290.00	1,435.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,935.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	375.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	9,790.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,605.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	110.00

TOTAL ANCILLARY	1,043,209.79	6,310.00
TOTAL ACCOMODATIONS	212,400.00	57,560.00
TOTAL CHARGES	1,255,609.79	63,870.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
46	2211188006584	05/08/11 - 05/13/11	07/11/11	0.00	110.00	0.00	0.00	0.00
TOTAL				0.00	110.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,679,445.46	ADJUSTMENTS	82,015.46
COVERED CHARGES	1,532,986.46	CONTRACTUAL ALLOW	1,190,007.97
NON-COVERD CHARGES	146,459.00	TOTAL MEDICAID LIAB	342,978.49
		LESS: COB	1,488.29
		LESS: COPAYMENT	1,530.00
		REIMBURSEMENT	339,960.20
		ALL OTHER	309,868.57
		FEE SCHEDULE-LAB	28,998.36
		INJECTABLE DRUGS	1,093.27

TOTAL NUMBER OF CLAIMS 1,273

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,971.70	1,080.00
MED/SURG SUPPLY	68,430.76	135.00
LABORATORY-GENERAL	0.00	150.00
RADIOLOGY-DIAGNOSTIC	116,060.00	1,385.00
CT SCAN	197,610.00	9,270.00
PHYSICAL THERAPY	14,885.00	210.00
EKG/ECG	19,170.00	0.00
IV THERAPY	16,835.00	2,100.00
OPERATING ROOM	60,732.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	22,085.00	125.00
ANESTHESIA	0.00	0.00
GI SERVICES	55,685.00	0.00
EMERGENCY ROOM	319,140.00	2,375.00
RECOVERY ROOM	4,050.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,765.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	48,000.00	0.00
OTHER IMAGING SERVICE	26,900.00	1,625.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,340.00	980.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,670.00	430.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,525.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,985.00	2,520.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,225.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	150.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	378,066.50	86,084.00
MRI SERVICES	48,880.00	2,930.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,975.00	34,910.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,532,986.46	146,459.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,532,986.46	146,459.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,175.20	ADJUSTMENTS	0.00
COVERED CHARGES	15,020.20	CONTRACTUAL ALLOW	9,805.61
NON-COVERD CHARGES	16,155.00	TOTAL MEDICAID LIAB	5,214.59
		LESS: COB	5,196.59
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	980.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,350.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,020.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,740.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,385.00	590.00
EKG/ECG	450.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,740.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,740.00	75.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	180.00	11,750.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	175.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,020.20	16,155.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,020.20	16,155.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	55,702.70	ADJUSTMENTS	49.94
COVERED CHARGES	54,077.70	CONTRACTUAL ALLOW	49,602.50
NON-COVERD CHARGES	1,625.00	TOTAL MEDICAID LIAB	4,475.20
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	4,364.20

TOTAL NUMBER OF CLAIMS 80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	950.20	0.00
MED/SURG SUPPLY	1,162.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,625.00	0.00
CT SCAN	7,380.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	600.00	0.00
IV THERAPY	1,200.00	0.00
OPERATING ROOM	0.00	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	28,075.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	285.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,545.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,545.00	840.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	610.00	615.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	54,077.70	1,625.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	54,077.70	1,625.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	780.00	ADJUSTMENTS	0.00
COVERED CHARGES	780.00	CONTRACTUAL ALLOW	525.78
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	254.22
		LESS: COB	254.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	390.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	390.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	780.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	780.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
PO BOX 518
CLAXTON,GA 30417-0518

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,892,778.58	ADJUSTMENTS	4,432,977.63
COVERED CHARGES	47,054,510.53	CONTRACTUAL ALLOW	33,414,466.24
NON-COVERD CHARGES	1,838,268.05	TOTAL MEDICAID LIAB	13,640,044.29
		LESS: COB	99,598.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,540,446.00

TOTAL NUMBER OF ADMISSIONS 1,866

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,448	7	2,724,000.00	922,850.00
ROUTINE NURSERY	1,282	0	880,270.00	102,855.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	0.00
TOTAL ROUTINE	6,730	13	3,604,270.00	1,025,705.00
SPECIAL CARE SERVICES				
CCU	1,491	0	1,279,080.00	0.00
ICU	1,278	0	1,752,300.00	0.00
NICU	208	0	384,384.00	0.00
PED ICU	43	0	52,030.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,020	0	3,467,794.00	0.00
TOTAL ACCOMODATIONS	9,750	13	7,072,064.00	1,025,705.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,102,978.75	674.00
MED/SURG SUPPLY	8,425,809.82	163,222.80
LABORATORY-GENERAL	5,554,745.60	7,602.00
RADIOLOGY-DIAGNOSTIC	783,714.00	0.00
CT SCAN	940,917.00	267,957.00
PHYSICAL THERAPY	120,199.00	63.00
EKG/ECG	614,604.00	0.00
IV THERAPY	155,394.00	731.25
OPERATING ROOM	3,416,900.84	12,414.00
LABOR/DELIVERY ROOM	1,312,297.00	0.00
RESPIRATORY SERVICES	3,074,430.00	22,329.00
ANESTHESIA	669,315.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,449,559.00	7,760.00
RECOVERY ROOM	370,404.00	0.00
LABORATORY PATHOLOGIC	150,498.00	816.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	20,056.00	0.00
SPEECH PATHOLOGY	35,945.00	304.00
RENAL DIALYSIS	179,416.00	26,759.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,512.00	2,087.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	13,952.00	0.00
OTHER IMAGING SERVICE	180,842.00	31,200.00
BLOOD	1,908.00	0.00
BLOOD STORAGE & PRO.	495,235.00	40,700.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	170,061.00	50,497.00
AUDIOLOGY	27,753.00	0.00
CARDIOLOGY	1,069,163.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	32,282.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	101,061.00	1,210.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	188,869.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,784.00	0.00
OTHER THERAPEUTIC SVC	0.00	144.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	220,799.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	137,270.00
INJECTABLE DRUGS	1,089,042.52	13,941.00
HOME HEALTH SERVICES	0.00	1,200.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	22,800.00
NO CC/INVALID REV CODE	0.00	882.00

TOTAL ANCILLARY	39,982,446.53	812,563.05
TOTAL ACCOMODATIONS	7,072,064.00	1,025,705.00
TOTAL CHARGES	47,054,510.53	1,838,268.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2601	4010222052583	07/01/10 - 07/01/10	09/27/10	0.00	522.00	0.00	0.00	0.00
2601	4410259134045	07/19/10 - 07/19/10	09/27/10	0.00	360.00	0.00	0.00	0.00
TOTAL				0.00	882.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	847,966.02	ADJUSTMENTS	0.00
COVERED CHARGES	698,230.83	CONTRACTUAL ALLOW	404,199.06
NON-COVERD CHARGES	149,735.19	TOTAL MEDICAID LIAB	294,031.77
		LESS: COB	294,031.77
		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	97	0	47,525.00	19,795.00
ROUTINE NURSERY	28	0	28,200.00	3,700.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	123,517.69
TOTAL ROUTINE	125	0	75,725.00	147,012.69
SPECIAL CARE SERVICES				
CCU	33	0	27,225.00	0.00
ICU	22	0	36,300.00	0.00
NICU	9	0	16,632.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	64	0	80,157.00	0.00
TOTAL ACCOMODATIONS	189	0	155,882.00	147,012.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,707.50	0.00
MED/SURG SUPPLY	119,324.33	1,409.00
LABORATORY-GENERAL	67,729.00	0.00
RADIOLOGY-DIAGNOSTIC	12,259.00	0.00
CT SCAN	2,067.00	0.00
PHYSICAL THERAPY	988.00	0.00
EKG/ECG	6,074.00	0.00
IV THERAPY	7,640.00	0.00
OPERATING ROOM	32,996.00	0.00
LABOR/DELIVERY ROOM	67,859.00	0.00
RESPIRATORY SERVICES	60,416.00	0.00
ANESTHESIA	14,189.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,002.00	0.00
RECOVERY ROOM	4,542.00	0.00
LABORATORY PATHOLOGIC	486.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	302.00	0.00
SPEECH PATHOLOGY	304.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	442.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,132.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,842.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	394.00	0.00
CARDIOLOGY	4,128.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	626.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,168.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,114.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,644.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,974.00	113.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	1,200.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	542,348.83	2,722.50
TOTAL ACCOMODATIONS	155,882.00	147,012.69
TOTAL CHARGES	698,230.83	149,735.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,229,225.14	ADJUSTMENTS	788,356.79
COVERED CHARGES	23,919,326.39	CONTRACTUAL ALLOW	19,205,481.53
NON-COVERD CHARGES	2,309,898.75	TOTAL MEDICAID LIAB	4,713,844.86
		LESS: COB	23,932.89
		LESS: COPAYMENT	9,528.72
		REIMBURSEMENT	4,680,383.25
		ALL OTHER	3,940,800.51
		FEE SCHEDULE-LAB	457,015.77
		INJECTABLE DRUGS	282,566.97

TOTAL NUMBER OF CLAIMS 11,927

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	731,133.25	5,314.75
MED/SURG SUPPLY	2,709,476.65	5,042.00
LABORATORY-GENERAL	0.00	773.00
RADIOLOGY-DIAGNOSTIC	947,233.00	52,077.00
CT SCAN	1,651,586.00	321,419.00
PHYSICAL THERAPY	84,550.80	22,544.00
EKG/ECG	365,938.00	2,893.00
IV THERAPY	281,474.00	23,056.00
OPERATING ROOM	1,776,676.00	704,539.00
LABOR/DELIVERY ROOM	211,931.00	0.00
RESPIRATORY SERVICES	148,902.00	17,104.00
ANESTHESIA	444,685.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,333,490.00	7,987.00
RECOVERY ROOM	518,559.00	1,047.00
LABORATORY PATHOLOGIC	0.00	379.00
RADIOLOGY THERAPEUTIC	9,540.00	0.00
OCCUPATIONAL THERAPY	0.00	380.00
SPEECH PATHOLOGY	760.00	912.00
RENAL DIALYSIS	0.00	3,479.00
OUTPATIENT SERVICES	89.00	0.00
CLINIC SERVICES	151,788.00	39,279.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	69,760.00	13,952.00
OTHER IMAGING SERVICE	306,935.00	18,350.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,360.00	15,856.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	290,180.00	44,589.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	420,803.00	95,142.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	156,606.00	1,126.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	732,322.00	34,782.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	124,586.00	7,365.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	7,773.00	72.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,633,958.49	420,117.50
MRI SERVICES	240,522.00	37,924.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	64.00	3,051.00
INJECTABLE DRUGS	2,546,645.20	383,003.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	25,200.00
NO CC/INVALID REV CODE	0.00	1,144.00

TOTAL ANCILLARY	23,919,326.39	2,309,898.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,919,326.39	2,309,898.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
6360	2212010014128	04/17/11 - 04/17/11	01/16/12	0.00	220.00	0.00	0.00	0.00
363	2212069021158	10/04/10 - 10/05/10	03/19/12	0.00	924.00	0.00	0.00	0.00
TOTAL				0.00	1,144.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	624,563.56	ADJUSTMENTS	0.00
COVERED CHARGES	548,119.06	CONTRACTUAL ALLOW	253,612.44
NON-COVERD CHARGES	76,444.50	TOTAL MEDICAID LIAB	294,506.62
		LESS: COB	294,419.61
		LESS: COPAYMENT	87.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	232

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,084.75	57.00	OTHER LAB	3,379.00	506.00
MED/SURG SUPPLY	68,971.81	599.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	17.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,000.00	664.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,365.00	6,599.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	150.00	FEE SCHEDULE LAB	83,535.00	7,897.00
EKG/ECG	6,206.00	0.00	MRI SERVICES	2,319.00	1,588.00
IV THERAPY	6,298.00	1,264.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,613.00	46,191.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,939.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,979.00	150.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,834.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	133,218.00	2,648.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,276.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,675.50	6,271.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,386.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	159.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,844.00	874.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,542.00	520.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,467.00	290.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,156.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,691.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,340.00	0.00			

TOTAL ANCILLARY	548,119.06	76,444.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	548,119.06	76,444.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,726,474.50	ADJUSTMENTS	18,206.71
COVERED CHARGES	1,699,138.00	CONTRACTUAL ALLOW	1,612,865.69
NON-COVERD CHARGES	27,336.50	TOTAL MEDICAID LIAB	86,272.31
		LESS: COB	0.00
		LESS: COPAYMENT	3,528.12
		REIMBURSEMENT	82,744.19

TOTAL NUMBER OF CLAIMS 1,704

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,917.25	9.00
MED/SURG SUPPLY	69,865.47	221.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,420.00	0.00
CT SCAN	64,459.00	2,562.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	14,000.00	250.00
IV THERAPY	4,171.00	154.00
OPERATING ROOM	7,403.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,377.00	450.00
ANESTHESIA	1,131.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,078,770.03	814.00
RECOVERY ROOM	1,743.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	573.00	34.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,926.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,395.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	256,864.00	11,529.00
MRI SERVICES	6,797.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	76,326.25	11,313.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,699,138.00	27,336.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,699,138.00	27,336.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,877.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,097.00	CONTRACTUAL ALLOW	20,353.55
NON-COVERD CHARGES	780.00	TOTAL MEDICAID LIAB	18,743.45
		LESS: COB	18,680.44
		LESS: COPAYMENT	63.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.00	0.00	OTHER LAB	479.00	0.00
MED/SURG SUPPLY	1,257.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,500.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,712.00	720.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,167.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,520.00	60.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	39,097.00	780.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,097.00	780.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,036,266.86	ADJUSTMENTS	44,853.76
COVERED CHARGES	3,755,608.86	CONTRACTUAL ALLOW	3,214,475.06
NON-COVERD CHARGES	280,658.00	TOTAL MEDICAID LIAB	541,133.80
		LESS: COB	6,884.68
		LESS: COPAYMENT	405.00
		REIMBURSEMENT	533,844.12

TOTAL NUMBER OF CLAIMS 109

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,815.50	0.00
MED/SURG SUPPLY	1,452,381.86	7,732.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,552.00	14,986.00
CT SCAN	66,145.00	9,360.00
PHYSICAL THERAPY	0.00	756.00
EKG/ECG	8,412.00	0.00
IV THERAPY	51,385.00	2,948.00
OPERATING ROOM	568,096.00	85,483.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,758.00	180.00
ANESTHESIA	105,937.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,016.00	0.00
RECOVERY ROOM	82,602.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,241.00	2,376.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,016.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,799.00	452.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,715.00	37,741.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	70,757.00	2,640.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	71,258.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	144.00	72.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	39,601.00	3,220.00
MRI SERVICES	10,286.00	3,096.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	58.00
INJECTABLE DRUGS	1,044,691.50	102,358.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	7,200.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,755,608.86	280,658.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,755,608.86	280,658.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,975.29	ADJUSTMENTS	0.00
COVERED CHARGES	25,708.79	CONTRACTUAL ALLOW	8,948.47
NON-COVERD CHARGES	266.50	TOTAL MEDICAID LIAB	16,760.32
		LESS: COB	16,754.32
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
PO BOX 233
ROME,GA 30162-0233

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	803.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,500.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,014.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	933.00	87.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,180.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,885.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	699.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,466.00	179.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,100.00	0.00			

TOTAL ANCILLARY	25,708.79	266.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,708.79	266.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,548,156.17	ADJUSTMENTS	851,979.53
COVERED CHARGES	20,154,504.67	CONTRACTUAL ALLOW	14,939,270.23
NON-COVERD CHARGES	1,393,651.50	TOTAL MEDICAID LIAB	5,215,234.44
		LESS: COB	78,125.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,137,109.01

TOTAL NUMBER OF ADMISSIONS 904

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,566	19	1,995,532.00	432,834.00
ROUTINE NURSERY	924	0	920,085.00	219,506.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	3,490	22	2,915,617.00	652,340.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	300	0	862,274.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	300	0	862,274.00	0.00
TOTAL ACCOMODATIONS	3,790	22	3,777,891.00	652,340.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	972,308.00	73,137.00
MED/SURG SUPPLY	1,588,389.50	13,740.50
LABORATORY-GENERAL	2,574,568.17	54,874.00
RADIOLOGY-DIAGNOSTIC	404,760.00	0.00
CT SCAN	638,206.00	60,739.00
PHYSICAL THERAPY	136,012.00	7,198.00
EKG/ECG	151,854.00	0.00
IV THERAPY	8,856.00	690.00
OPERATING ROOM	1,021,701.00	9,195.00
LABOR/DELIVERY ROOM	699,755.00	0.00
RESPIRATORY SERVICES	1,191,781.00	464.00
ANESTHESIA	120,438.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	777,705.00	2,582.00
RECOVERY ROOM	136,293.00	0.00
LABORATORY PATHOLOGIC	129,493.00	0.00
RADIOLOGY THERAPEUTIC	60,492.00	65,089.00
OCCUPATIONAL THERAPY	28,547.00	0.00
SPEECH PATHOLOGY	23,969.00	1,809.00
RENAL DIALYSIS	140,756.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	58.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	166,574.00	31,380.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	171,823.00	13,740.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	134,822.00	23,386.00
AUDIOLOGY	70,769.00	0.00
CARDIOLOGY	734,387.00	1,865.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,300.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,427.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,599.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	871.00	0.00
OTHER THERAPEUTIC SVC	0.00	13,102.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	174,376.00	4,010.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	1,297.00
DRUG-SPECIFIC/HOME IV	0.00	20,924.50
INJECTABLE DRUGS	4,042,724.00	342,089.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,376,613.67	741,311.50
TOTAL ACCOMODATIONS	3,777,891.00	652,340.00
TOTAL CHARGES	20,154,504.67	1,393,651.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	436,511.50	ADJUSTMENTS	0.00
COVERED CHARGES	416,378.50	CONTRACTUAL ALLOW	251,473.42
NON-COVERD CHARGES	20,133.00	TOTAL MEDICAID LIAB	164,905.08
		LESS: COB	164,905.08
		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	27	0	21,465.00	4,515.00
ROUTINE NURSERY	17	0	27,735.00	14,071.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	44	0	49,200.00	18,586.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	48	0	126,048.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	48	0	126,048.00	0.00
TOTAL ACCOMODATIONS	92	0	175,248.00	18,586.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,169.00	0.00
MED/SURG SUPPLY	31,263.00	218.00
LABORATORY-GENERAL	32,064.00	0.00
RADIOLOGY-DIAGNOSTIC	1,888.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,230.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	16,156.00	0.00
LABOR/DELIVERY ROOM	30,406.00	0.00
RESPIRATORY SERVICES	6,298.00	0.00
ANESTHESIA	4,654.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,294.00	0.00
RECOVERY ROOM	1,902.00	0.00
LABORATORY PATHOLOGIC	2,215.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,092.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,098.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,072.00	0.00
CARDIOLOGY	31,088.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	62.00	0.00
OTHER THERAPEUTIC SVC	0.00	252.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,262.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	1,077.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,917.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	241,130.50	1,547.00
TOTAL ACCOMODATIONS	175,248.00	18,586.00
TOTAL CHARGES	416,378.50	20,133.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,823,881.22	ADJUSTMENTS	401,891.50
COVERED CHARGES	9,390,035.62	CONTRACTUAL ALLOW	7,592,162.26
NON-COVERD CHARGES	1,433,845.60	TOTAL MEDICAID LIAB	1,797,873.36
		LESS: COB	7,707.98
		LESS: COPAYMENT	4,614.60
		REIMBURSEMENT	1,785,550.78
		ALL OTHER	1,555,837.15
		FEE SCHEDULE-LAB	91,313.39
		INJECTABLE DRUGS	138,400.24

TOTAL NUMBER OF CLAIMS 3,195

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252,696.00	2,913.50
MED/SURG SUPPLY	477,925.00	23,903.00
LABORATORY-GENERAL	0.00	95.00
RADIOLOGY-DIAGNOSTIC	387,623.00	17,116.00
CT SCAN	854,039.00	119,941.00
PHYSICAL THERAPY	19,202.00	8,144.00
EKG/ECG	70,122.00	246.00
IV THERAPY	266,521.00	51,166.00
OPERATING ROOM	613,496.00	109,221.00
LABOR/DELIVERY ROOM	67,861.00	0.00
RESPIRATORY SERVICES	74,164.00	1,098.00
ANESTHESIA	96,686.00	11,585.00
GI SERVICES	3,991.00	0.00
EMERGENCY ROOM	1,968,014.00	38,072.00
RECOVERY ROOM	107,250.00	2,108.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	337,647.00	5,445.00
OCCUPATIONAL THERAPY	6,033.00	3,800.00
SPEECH PATHOLOGY	3,414.00	2,050.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	406.00	435.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	536,367.00	76,927.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	44,600.00	37,128.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	185,544.00	17,858.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	181,214.00	127,241.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,150.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	179,916.00	1,768.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	101,589.00	3,578.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	758.00	705.00
OTHER THERAPEUTIC SVC	0.00	39,706.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,326,185.62	234,357.60
MRI SERVICES	187,584.00	3,262.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,038,038.00	493,976.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,390,035.62	1,433,845.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,390,035.62	1,433,845.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	299,965.90	ADJUSTMENTS	0.00
COVERED CHARGES	217,117.40	CONTRACTUAL ALLOW	128,996.06
NON-COVERD CHARGES	82,848.50	TOTAL MEDICAID LIAB	88,121.34
		LESS: COB	88,078.28
		LESS: COPAYMENT	43.06
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 102

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,607.00	159.50
MED/SURG SUPPLY	13,988.00	282.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,375.00	0.00
CT SCAN	14,522.00	18,264.00
PHYSICAL THERAPY	0.00	435.00
EKG/ECG	738.00	0.00
IV THERAPY	3,869.00	5,691.00
OPERATING ROOM	10,498.00	16,854.00
LABOR/DELIVERY ROOM	7,911.00	0.00
RESPIRATORY SERVICES	2,387.00	0.00
ANESTHESIA	6,064.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	58,519.00	1,525.00
RECOVERY ROOM	7,541.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,644.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	87.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,340.00	9,368.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	9,643.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	575.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,911.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	675.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	417.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	41,194.40	8,000.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,759.00	12,123.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	217,117.40	82,848.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,117.40	82,848.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	503,223.20	ADJUSTMENTS	1,503.29
COVERED CHARGES	456,678.20	CONTRACTUAL ALLOW	436,506.23
NON-COVERD CHARGES	46,545.00	TOTAL MEDICAID LIAB	20,171.97
		LESS: COB	413.00
		LESS: COPAYMENT	573.05
		REIMBURSEMENT	19,185.92

TOTAL NUMBER OF CLAIMS 353

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,686.00	0.00
MED/SURG SUPPLY	7,172.00	341.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,418.00	0.00
CT SCAN	34,460.00	7,214.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,428.00	0.00
IV THERAPY	1,307.00	3,252.00
OPERATING ROOM	0.00	2,835.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	141.00	0.00
ANESTHESIA	500.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	254,240.00	4,619.00
RECOVERY ROOM	380.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,255.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,167.00	2,463.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,836.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	629.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	68,952.20	13,028.00
MRI SERVICES	7,272.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,835.00	12,793.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	456,678.20	46,545.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	456,678.20	46,545.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,176.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,065.00	CONTRACTUAL ALLOW	6,000.28
NON-COVERD CHARGES	4,111.50	TOTAL MEDICAID LIAB	3,064.72
		LESS: COB	3,064.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	99.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	244.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,058.00	464.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,003.00	22.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	236.00	760.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	502.00	1,338.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,428.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,065.00	4,111.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,065.00	4,111.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,317,527.50	ADJUSTMENTS	86,164.82
COVERED CHARGES	3,864,950.50	CONTRACTUAL ALLOW	3,284,371.79
NON-COVERD CHARGES	452,577.00	TOTAL MEDICAID LIAB	580,578.71
		LESS: COB	0.00
		LESS: COPAYMENT	1,175.70
		REIMBURSEMENT	579,403.01

TOTAL NUMBER OF CLAIMS 106

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,420.50	30,539.50
MED/SURG SUPPLY	292,863.00	1,698.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,729.00	0.00
CT SCAN	66,221.00	1,667.00
PHYSICAL THERAPY	0.00	789.00
EKG/ECG	3,210.00	246.00
IV THERAPY	98,078.00	3,316.00
OPERATING ROOM	84,656.00	20,075.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,286.00	0.00
ANESTHESIA	13,431.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,747.00	271.00
RECOVERY ROOM	4,317.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	589,517.00	43,162.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,674.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,328.00	7,140.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,086.00	954.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	66,211.00	10,423.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,473.00	707.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,950.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	98,238.00	8,970.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,425,465.00	315,106.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	563.00

TOTAL ANCILLARY	3,864,950.50	452,577.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,864,950.50	452,577.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2605	2211285008552	07/19/11 - 07/19/11	10/17/11	0.00	563.00	0.00	0.00	0.00
TOTAL				0.00	563.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,535.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,058.50	CONTRACTUAL ALLOW	-3,770.80
NON-COVERD CHARGES	22,477.00	TOTAL MEDICAID LIAB	29,829.30
		LESS: COB	29,823.30
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	468.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	288.00	44.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,495.00	22,433.00
RADIOLOGY THERAPEUTIC	2,200.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,058.50	22,477.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,058.50	22,477.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,546,374.81	ADJUSTMENTS	357,319.31
COVERED CHARGES	2,496,024.16	CONTRACTUAL ALLOW	-133,021.75
NON-COVERD CHARGES	50,350.65	TOTAL MEDICAID LIAB	2,629,045.91
		LESS: COB	2,161.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,626,883.98

TOTAL NUMBER OF ADMISSIONS 122

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,851	8	1,508,100.00	25,575.00
ROUTINE NURSERY	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	1,851	8	1,508,100.00	25,575.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,851	8	1,508,100.00	25,575.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247,306.26	15,847.48
MED/SURG SUPPLY	32,758.90	1,453.17
LABORATORY-GENERAL	62,807.00	662.00
RADIOLOGY-DIAGNOSTIC	12,019.00	0.00
CT SCAN	10,895.00	0.00
PHYSICAL THERAPY	205,023.00	2,144.00
EKG/ECG	7,260.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,553.00	626.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,523.00	0.00
EMERGENCY ROOM	3,322.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	252,843.00	2,606.00
SPEECH PATHOLOGY	108,598.00	378.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,756.00	0.00
BLOOD	3,707.00	0.00
BLOOD STORAGE & PRO.	2,585.00	517.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,335.00	467.00
RECREATIONAL THERAPY	2,819.00	75.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,814.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	987,924.16	24,775.65
TOTAL ACCOMODATIONS	1,508,100.00	25,575.00
TOTAL CHARGES	2,496,024.16	50,350.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,759.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,541.00	CONTRACTUAL ALLOW	5,131.85
NON-COVERD CHARGES	218.00	TOTAL MEDICAID LIAB	28,409.15
		LESS: COB	28,409.15
		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	26	0	21,450.00	0.00
ROUTINE NURSERY	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	26	0	21,450.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	26	0	21,450.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,002.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	90.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,347.00	218.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,220.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	66.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,727.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,639.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,091.00	218.00
TOTAL ACCOMODATIONS	21,450.00	0.00
TOTAL CHARGES	33,541.00	218.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,451.00	ADJUSTMENTS	10,888.98
COVERED CHARGES	39,201.00	CONTRACTUAL ALLOW	6,257.26
NON-COVERD CHARGES	3,250.00	TOTAL MEDICAID LIAB	32,943.74
		LESS: COB	293.47
		LESS: COPAYMENT	648.00
		REIMBURSEMENT	32,002.27
		ALL OTHER	31,980.76
		FEE SCHEDULE-LAB	21.51
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 126

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	1,622.00	0.00
MED/SURG SUPPLY	0.00	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	576.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,774.00	1,210.00	FEE SCHEDULE LAB	188.00	113.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,707.00	1,689.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	690.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,644.00	213.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	39,201.00	3,250.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,201.00	3,250.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS HOSPITAL
PO BOX 1000
WARM SPRINGS,GA 31830-1000

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	154,282,084.26	ADJUSTMENTS	7,585,493.19
COVERED CHARGES	151,756,040.39	CONTRACTUAL ALLOW	121,456,494.33
NON-COVERD CHARGES	2,526,043.87	TOTAL MEDICAID LIAB	30,299,546.06
		LESS: COB	155,547.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,143,998.19

TOTAL NUMBER OF ADMISSIONS 4,538

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13,658	13	16,078,020.20	1,024,276.20
ROUTINE NURSERY	4,104	0	4,073,115.99	62,941.98
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	2.00
TOTAL ROUTINE	17,762	13	20,151,136.19	1,087,220.18
SPECIAL CARE SERVICES				
CCU	650	0	2,078,160.47	0.00
ICU	2,892	0	8,084,269.80	0.00
NICU	250	0	733,799.70	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,792	0	10,896,229.97	0.00
TOTAL ACCOMODATIONS	21,554	13	31,047,366.16	1,087,220.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,580,359.95	62,306.52
MED/SURG SUPPLY	16,757,354.42	395,457.09
LABORATORY-GENERAL	12,289,044.49	10,178.16
RADIOLOGY-DIAGNOSTIC	2,662,901.90	518.17
CT SCAN	4,311,084.57	25,856.94
PHYSICAL THERAPY	633,954.29	4,414.43
EKG/ECG	480,543.65	0.00
IV THERAPY	7,791.00	0.00
OPERATING ROOM	10,297,777.90	52,717.18
LABOR/DELIVERY ROOM	7,040,966.26	0.00
RESPIRATORY SERVICES	5,826,335.25	1,302.01
ANESTHESIA	4,993,865.10	0.00
GI SERVICES	404,843.28	0.00
EMERGENCY ROOM	2,290,382.73	38,090.80
RECOVERY ROOM	3,470,661.21	2,832.34
LABORATORY PATHOLOGIC	442,459.16	0.00
RADIOLOGY THERAPEUTIC	9,897.70	0.00
OCCUPATIONAL THERAPY	343,138.40	3,282.20
SPEECH PATHOLOGY	410,740.67	9,498.52
RENAL DIALYSIS	184,880.49	29,917.44
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,858.53	267.93
PSYCHIATRIC SERVICES	702,808.90	804.82
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	825,142.22	32,294.44
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	563,759.76	18,280.62
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,025,568.56	0.00
AUDIOLOGY	194,400.97	0.00
CARDIOLOGY	2,065,770.82	1,334.02
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	103,079.45	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	149,123.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	318,569.59	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	28,200.00	720.00
OTHER THERAPEUTIC SVC	170,505.68	84,091.34
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,115,203.84	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,699.63	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	664,658.72
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	120,708,674.23	1,438,823.69
TOTAL ACCOMODATIONS	31,047,366.16	1,087,220.18
TOTAL CHARGES	151,756,040.39	2,526,043.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,007,344.80	ADJUSTMENTS	0.00
COVERED CHARGES	1,001,616.40	CONTRACTUAL ALLOW	855,910.92
NON-COVERD CHARGES	5,728.40	TOTAL MEDICAID LIAB	145,705.48
		LESS: COB	145,705.48
		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	57	0	67,374.00	3,386.94
ROUTINE NURSERY	61	0	111,106.68	2,341.46
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	118	0	178,480.68	5,728.40
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	33	0	102,238.14	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	33	0	102,238.14	0.00
TOTAL ACCOMODATIONS	151	0	280,718.82	5,728.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	208,977.63	0.00
MED/SURG SUPPLY	96,440.06	0.00
LABORATORY-GENERAL	80,649.26	0.00
RADIOLOGY-DIAGNOSTIC	4,575.51	0.00
CT SCAN	17,450.40	0.00
PHYSICAL THERAPY	3,393.53	0.00
EKG/ECG	1,907.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,445.10	0.00
LABOR/DELIVERY ROOM	65,233.84	0.00
RESPIRATORY SERVICES	87,632.82	0.00
ANESTHESIA	24,751.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,363.79	0.00
RECOVERY ROOM	18,207.90	0.00
LABORATORY PATHOLOGIC	1,666.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,971.23	0.00
SPEECH PATHOLOGY	11,786.68	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,506.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	478.48	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,149.58	0.00
AUDIOLOGY	126.18	0.00
CARDIOLOGY	16,133.98	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,597.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	710.08	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	427.77	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,314.96	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	720,897.58	0.00
TOTAL ACCOMODATIONS	280,718.82	5,728.40
TOTAL CHARGES	1,001,616.40	5,728.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,410,519.50	ADJUSTMENTS	286,277.47
COVERED CHARGES	20,649,918.81	CONTRACTUAL ALLOW	16,810,543.88
NON-COVERD CHARGES	2,760,600.69	TOTAL MEDICAID LIAB	3,839,374.93
		LESS: COB	6,771.48
		LESS: COPAYMENT	7,302.34
		REIMBURSEMENT	3,825,301.11
		ALL OTHER	3,653,812.77
		FEE SCHEDULE-LAB	149,616.81
		INJECTABLE DRUGS	21,871.53

TOTAL NUMBER OF CLAIMS 7,433

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840,558.79	26,887.33
MED/SURG SUPPLY	1,080,791.71	387,072.10
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,547,134.19	31,830.08
CT SCAN	1,607,526.24	665,445.23
PHYSICAL THERAPY	29,034.54	4,957.06
EKG/ECG	306,350.16	1,563.98
IV THERAPY	151,362.10	9,532.76
OPERATING ROOM	1,335,145.95	415,487.17
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	122,249.00	3,591.43
ANESTHESIA	902,941.98	0.00
GI SERVICES	84,703.50	35,563.49
EMERGENCY ROOM	5,299,262.88	41,334.64
RECOVERY ROOM	350,983.64	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,578.69	2,765.96
SPEECH PATHOLOGY	0.00	2,220.98
RENAL DIALYSIS	0.00	7,806.61
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	187,218.40	8,363.32
PSYCHIATRIC SERVICES	207,179.96	0.00
LITHOTRIPSY	0.00	49,202.36
OTHER IMAGING SERVICE	610,400.39	63,349.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,917.92	7,025.16
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	419,667.63	5,186.05
AUDIOLOGY	5,237.97	2,047.78
CARDIOLOGY	201,268.36	97,136.06
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	521,687.23	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	146,072.48	18,217.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	102,340.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,080.00
OTHER THERAPEUTIC SVC	0.00	4,645.93
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,165,220.51	285,892.60
MRI SERVICES	310,446.74	16,913.45
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,629.00
INJECTABLE DRUGS	1,093,637.35	489,874.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	70,978.32
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,649,918.81	2,760,600.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,649,918.81	2,760,600.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107,378.46	ADJUSTMENTS	0.00
COVERED CHARGES	78,959.93	CONTRACTUAL ALLOW	48,001.33
NON-COVERD CHARGES	28,418.53	TOTAL MEDICAID LIAB	30,958.60
		LESS: COB	30,938.63
		LESS: COPAYMENT	19.97
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,952.24	2,211.62
MED/SURG SUPPLY	12,081.23	716.83
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	798.21	0.00
CT SCAN	2,376.99	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,144.38	0.00
IV THERAPY	2,612.92	0.00
OPERATING ROOM	9,042.43	6,497.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	7,508.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,021.59	387.31
RECOVERY ROOM	2,987.75	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	550.14	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,107.95	437.69
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	13,266.38
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,649.36	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,174.99	619.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,951.75	4,281.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	78,959.93	28,418.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,959.93	28,418.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,662,806.51	ADJUSTMENTS	267.70
COVERED CHARGES	1,601,343.98	CONTRACTUAL ALLOW	1,539,138.74
NON-COVERD CHARGES	61,462.53	TOTAL MEDICAID LIAB	62,205.24
		LESS: COB	0.00
		LESS: COPAYMENT	2,289.16
		REIMBURSEMENT	59,916.08

TOTAL NUMBER OF CLAIMS 1,112

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,148.15	622.90
MED/SURG SUPPLY	25,845.61	388.29
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,759.75	0.00
CT SCAN	39,032.97	23,545.78
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	19,244.63	0.00
IV THERAPY	3,835.82	125.68
OPERATING ROOM	7,814.19	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	733.74	0.00
ANESTHESIA	3,803.61	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	943,887.26	3,348.73
RECOVERY ROOM	3,998.48	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,558.92	39.69
PSYCHIATRIC SERVICES	9,698.08	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,460.88	8,940.29
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,854.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,166.21	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	361,997.19	11,505.77
MRI SERVICES	6,140.92	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64,362.59	12,945.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,601,343.98	61,462.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,601,343.98	61,462.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,374.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,365.93	CONTRACTUAL ALLOW	350.48
NON-COVERD CHARGES	8.82	TOTAL MEDICAID LIAB	3,015.45
		LESS: COB	3,009.45
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	770.65	8.82
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,423.32	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,171.96	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,365.93	8.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,365.93	8.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,457,359.56	ADJUSTMENTS	47,408.17
COVERED CHARGES	3,773,351.20	CONTRACTUAL ALLOW	3,134,450.00
NON-COVERD CHARGES	684,008.36	TOTAL MEDICAID LIAB	638,901.20
		LESS: COB	0.00
		LESS: COPAYMENT	411.00
		REIMBURSEMENT	638,490.20

TOTAL NUMBER OF CLAIMS 119

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	251,697.17	7,204.07
MED/SURG SUPPLY	654,217.17	285,637.38
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,076.45	10,540.64
CT SCAN	98,129.45	19,939.84
PHYSICAL THERAPY	1,380.87	3,241.35
EKG/ECG	24,165.47	0.00
IV THERAPY	1,071.30	125.68
OPERATING ROOM	1,068,511.05	109,949.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,746.41	121.28
ANESTHESIA	465,629.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	51,499.63	1,508.16
RECOVERY ROOM	183,817.78	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,865.43
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,869.84
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	181.60
PSYCHIATRIC SERVICES	1,609.64	0.00
LITHOTRIPSY	223,870.74	24,601.18
OTHER IMAGING SERVICE	3,025.65	437.69
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	149,188.69	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	89,685.37	20,011.49
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	44,694.72	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,665.76	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	168,975.09	29,145.84
MRI SERVICES	10,030.10	3,195.04
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	210,663.54	128,034.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	36,397.24
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,773,351.20	684,008.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,773,351.20	684,008.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,590,346.14	ADJUSTMENTS	209,966.12
COVERED CHARGES	1,562,758.94	CONTRACTUAL ALLOW	863,833.99
NON-COVERD CHARGES	27,587.20	TOTAL MEDICAID LIAB	698,924.95
		LESS: COB	4,516.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	694,408.93

TOTAL NUMBER OF ADMISSIONS 163

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	303	0	260,277.00	25,116.00
ROUTINE NURSERY	139	0	110,783.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	442	1	371,060.00	25,116.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	49	0	86,730.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	49	0	86,730.00	0.00
TOTAL ACCOMODATIONS	491	1	457,790.00	25,116.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	291,839.63	10.20
MED/SURG SUPPLY	79,191.31	83.00
LABORATORY-GENERAL	123,615.00	264.00
RADIOLOGY-DIAGNOSTIC	22,618.00	0.00
CT SCAN	52,820.00	0.00
PHYSICAL THERAPY	8,323.00	0.00
EKG/ECG	11,102.00	0.00
IV THERAPY	4,776.00	0.00
OPERATING ROOM	150,956.00	0.00
LABOR/DELIVERY ROOM	57,764.00	0.00
RESPIRATORY SERVICES	62,026.00	0.00
ANESTHESIA	49,091.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,085.00	0.00
RECOVERY ROOM	26,266.00	0.00
LABORATORY PATHOLOGIC	10,711.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	588.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,784.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,782.00	1,938.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,607.00	0.00
AUDIOLOGY	3,362.00	0.00
CARDIOLOGY	20,017.00	0.00
AMBULATORY SURGERY	3,342.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	877.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,944.00	176.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,206.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	28,276.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,104,968.94	2,471.20
TOTAL ACCOMODATIONS	457,790.00	25,116.00
TOTAL CHARGES	1,562,758.94	27,587.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	172,657.45	ADJUSTMENTS	0.00
COVERED CHARGES	169,025.45	CONTRACTUAL ALLOW	26,551.52
NON-COVERD CHARGES	3,632.00	TOTAL MEDICAID LIAB	142,473.93
		LESS: COB	142,473.93
		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	68	0	58,412.00	3,632.00
ROUTINE NURSERY	7	0	5,579.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	75	0	63,991.00	3,632.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	75	0	63,991.00	3,632.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,951.45	0.00
MED/SURG SUPPLY	13,546.00	0.00
LABORATORY-GENERAL	10,099.00	0.00
RADIOLOGY-DIAGNOSTIC	1,025.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	330.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	608.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,583.00	0.00
RESPIRATORY SERVICES	618.00	0.00
ANESTHESIA	865.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	992.00	0.00
RECOVERY ROOM	519.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,240.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,170.00	0.00
AUDIOLOGY	164.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,092.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	444.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,788.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	105,034.45	0.00
TOTAL ACCOMODATIONS	63,991.00	3,632.00
TOTAL CHARGES	169,025.45	3,632.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,640,499.26	ADJUSTMENTS	186,025.50
COVERED CHARGES	2,471,627.74	CONTRACTUAL ALLOW	1,829,801.97
NON-COVERD CHARGES	168,871.52	TOTAL MEDICAID LIAB	641,825.77
		LESS: COB	3,900.24
		LESS: COPAYMENT	2,151.00
		REIMBURSEMENT	635,774.53
		ALL OTHER	505,555.60
		FEE SCHEDULE-LAB	106,914.41
		INJECTABLE DRUGS	23,304.52

TOTAL NUMBER OF CLAIMS 2,732

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,417.50	1,234.88
MED/SURG SUPPLY	64,068.61	0.00
LABORATORY-GENERAL	0.00	273.00
RADIOLOGY-DIAGNOSTIC	159,063.65	3,364.00
CT SCAN	232,917.00	33,796.00
PHYSICAL THERAPY	710.00	416.00
EKG/ECG	40,250.00	0.00
IV THERAPY	17,800.00	0.00
OPERATING ROOM	90,466.50	10,050.50
LABOR/DELIVERY ROOM	17,582.00	1,572.00
RESPIRATORY SERVICES	56,070.00	1,476.00
ANESTHESIA	23,415.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	661,047.20	7,181.00
RECOVERY ROOM	12,360.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,340.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,279.00	5,040.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,242.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,763.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,433.00	0.00
AMBULATORY SURGERY	19,120.00	2,868.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,139.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	98,587.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,122.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	345.00	120.00
OTHER THERAPEUTIC SVC	0.00	327.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	486,983.43	69,001.20
MRI SERVICES	46,569.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	138,537.85	31,552.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	599.90

TOTAL ANCILLARY	2,471,627.74	168,871.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,471,627.74	168,871.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2210301003847	10/10/10 - 10/10/10	11/15/10	0.00	340.00	0.00	0.00	0.00
2636	5911173001617	04/25/11 - 04/25/11	06/27/11	0.00	259.90	0.00	0.00	0.00
TOTAL				0.00	599.90	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,967.10	ADJUSTMENTS	0.00
COVERED CHARGES	60,161.38	CONTRACTUAL ALLOW	19,569.55
NON-COVERD CHARGES	7,805.72	TOTAL MEDICAID LIAB	40,591.83
		LESS: COB	40,585.83
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,466.63	0.00
MED/SURG SUPPLY	3,404.27	0.00
LABORATORY-GENERAL	0.00	14.00
RADIOLOGY-DIAGNOSTIC	4,286.00	724.00
CT SCAN	975.00	2,925.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,092.00	0.00
IV THERAPY	692.00	0.00
OPERATING ROOM	3,676.00	0.00
LABOR/DELIVERY ROOM	540.00	0.00
RESPIRATORY SERVICES	1,258.00	0.00
ANESTHESIA	838.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,617.40	527.10
RECOVERY ROOM	179.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	19.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	848.00	1,532.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,347.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,154.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,602.10	1,484.00
MRI SERVICES	1,625.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,541.98	599.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	60,161.38	7,805.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,161.38	7,805.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	189,848.18	ADJUSTMENTS	3,696.03
COVERED CHARGES	179,177.92	CONTRACTUAL ALLOW	159,625.62
NON-COVERD CHARGES	10,670.26	TOTAL MEDICAID LIAB	19,552.30
		LESS: COB	0.00
		LESS: COPAYMENT	456.02
		REIMBURSEMENT	19,096.28

TOTAL NUMBER OF CLAIMS 356

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,839.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	806.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,106.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,811.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,858.00	2,875.20
EKG/ECG	728.00	0.00	MRI SERVICES	3,576.00	3,576.00
IV THERAPY	598.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	502.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,160.00	41.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	119,114.00	1,004.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,173.86	2,672.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	3,102.00	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,306.00	0.00			

TOTAL ANCILLARY	179,177.92	10,670.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	179,177.92	10,670.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,556.59	ADJUSTMENTS	0.00
COVERED CHARGES	4,556.59	CONTRACTUAL ALLOW	2,659.43
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,897.16
		LESS: COB	1,891.16
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	919.00	0.00
EKG/ECG	182.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,050.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,556.59	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,556.59	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,429.56	ADJUSTMENTS	0.00
COVERED CHARGES	69,429.56	CONTRACTUAL ALLOW	49,589.04
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	19,840.52
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	19,828.52

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,617.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	66,780.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	69,429.56	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,429.56	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S E GA HEALTH SYS CAMDEN CAMPUS
PO BOX 1074
BRUNSWICK,GA 31521-1074

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,245,668.50	ADJUSTMENTS	1,812,165.19
COVERED CHARGES	24,657,801.96	CONTRACTUAL ALLOW	16,542,792.86
NON-COVERD CHARGES	587,866.54	TOTAL MEDICAID LIAB	8,115,009.10
		LESS: COB	36,504.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,078,504.42

TOTAL NUMBER OF ADMISSIONS 973

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,364	5	2,850,793.00	195,236.00
ROUTINE NURSERY	285	0	227,269.00	142.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	14	0.00	0.00
TOTAL ROUTINE	3,649	19	3,078,062.00	195,378.00
SPECIAL CARE SERVICES				
CCU	413	0	731,010.00	0.00
ICU	1,632	0	2,394,027.00	0.00
NICU	61	0	88,084.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,106	0	3,213,121.00	0.00
TOTAL ACCOMODATIONS	5,755	19	6,291,183.00	195,378.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,128,173.78	21,679.08
MED/SURG SUPPLY	2,094,450.23	38,464.46
LABORATORY-GENERAL	2,127,908.59	18,713.00
RADIOLOGY-DIAGNOSTIC	459,852.00	820.00
CT SCAN	512,575.00	117,940.00
PHYSICAL THERAPY	120,577.00	1,000.00
EKG/ECG	100,374.00	366.00
IV THERAPY	172,243.00	11,360.00
OPERATING ROOM	1,906,040.00	0.00
LABOR/DELIVERY ROOM	155,705.00	0.00
RESPIRATORY SERVICES	1,039,230.00	2,553.00
ANESTHESIA	430,581.12	0.00
GI SERVICES	827.00	0.00
EMERGENCY ROOM	426,366.00	1,356.00
RECOVERY ROOM	159,119.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	77,253.00	0.00
OCCUPATIONAL THERAPY	70,741.00	928.00
SPEECH PATHOLOGY	13,391.00	0.00
RENAL DIALYSIS	320,740.00	68,142.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	806.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	104,230.00	10,111.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	649,706.00	69,124.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	68,551.00	18,461.00
AUDIOLOGY	9,761.00	82.00
CARDIOLOGY	761,939.04	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,262.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	90,156.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	98,556.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	910.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	220,775.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	13,500.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	9,673.00

TOTAL ANCILLARY	18,366,618.96	392,488.54
TOTAL ACCOMODATIONS	6,291,183.00	195,378.00
TOTAL CHARGES	24,657,801.96	587,866.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	4010187071077	05/20/10 - 05/20/10	07/12/10	0.00	14.00	0.00	0.00	0.00
615	4010292036572	05/15/10 - 05/15/10	10/25/10	0.00	2,596.00	0.00	0.00	0.00
3	2210341003249	11/17/10 - 12/01/10	12/13/10	0.00	83.00	0.00	0.00	0.00
615	2210356013136	08/29/10 - 09/02/10	12/27/10	0.00	2,596.00	0.00	0.00	0.00
615	2211035008771	01/14/11 - 01/25/11	03/07/11	0.00	1,788.00	0.00	0.00	0.00
181	2211042014053	12/22/10 - 12/27/10	02/14/11	0.00	0.00	0.00	0.00	0.00
615	2211045004179	12/16/10 - 12/21/10	02/21/11	0.00	2,596.00	0.00	0.00	0.00
TOTAL				0.00	9,673.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	353,506.65	ADJUSTMENTS	0.00
COVERED CHARGES	328,050.74	CONTRACTUAL ALLOW	96,717.78
NON-COVERD CHARGES	25,455.91	TOTAL MEDICAID LIAB	231,332.96
		LESS: COB	231,332.96
		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	58	0	49,822.00	3,034.00
ROUTINE NURSERY	2	0	1,594.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	51,416.00	3,034.00
SPECIAL CARE SERVICES				
CCU	3	0	5,310.00	0.00
ICU	18	0	25,305.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	21	0	30,615.00	0.00
TOTAL ACCOMODATIONS	81	0	82,031.00	3,034.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,475.74	0.00
MED/SURG SUPPLY	11,258.00	19,026.91
LABORATORY-GENERAL	37,725.00	0.00
RADIOLOGY-DIAGNOSTIC	8,747.00	0.00
CT SCAN	2,962.00	3,268.00
PHYSICAL THERAPY	1,753.00	0.00
EKG/ECG	366.00	0.00
IV THERAPY	434.00	0.00
OPERATING ROOM	23,598.00	0.00
LABOR/DELIVERY ROOM	4,078.00	0.00
RESPIRATORY SERVICES	9,247.00	0.00
ANESTHESIA	4,636.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,724.00	0.00
RECOVERY ROOM	2,076.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,822.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	20,790.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	994.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,668.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	765.00	127.00
AUDIOLOGY	82.00	0.00
CARDIOLOGY	1,794.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,147.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,090.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,788.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	246,019.74	22,421.91
TOTAL ACCOMODATIONS	82,031.00	3,034.00
TOTAL CHARGES	328,050.74	25,455.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,221,745.40	ADJUSTMENTS	873,359.47
COVERED CHARGES	9,127,262.39	CONTRACTUAL ALLOW	6,184,332.52
NON-COVERD CHARGES	1,094,483.01	TOTAL MEDICAID LIAB	2,942,929.87
		LESS: COB	5,066.07
		LESS: COPAYMENT	9,619.09
		REIMBURSEMENT	2,928,244.71
		ALL OTHER	2,535,111.96
		FEE SCHEDULE-LAB	250,975.92
		INJECTABLE DRUGS	142,156.83

TOTAL NUMBER OF CLAIMS 6,821

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	693,996.34	12,987.35
MED/SURG SUPPLY	381,256.47	99,247.80
LABORATORY-GENERAL	0.00	1,141.30
RADIOLOGY-DIAGNOSTIC	463,337.00	21,869.00
CT SCAN	815,702.00	139,008.00
PHYSICAL THERAPY	61,717.00	29,522.00
EKG/ECG	92,943.00	923.00
IV THERAPY	113,424.29	389.00
OPERATING ROOM	539,765.95	74,685.04
LABOR/DELIVERY ROOM	25,747.00	4,762.00
RESPIRATORY SERVICES	112,093.00	22,605.00
ANESTHESIA	117,677.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,661,726.00	16,674.00
RECOVERY ROOM	91,304.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	660,638.00	20,659.00
OCCUPATIONAL THERAPY	14,574.00	7,869.00
SPEECH PATHOLOGY	4,078.00	3,827.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,515.00	2,161.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,610.00	0.00
OTHER IMAGING SERVICE	368,405.00	23,262.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	75,215.00	9,402.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	94,592.00	49,496.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	188,956.00	52,939.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,384.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	272,026.35	7,086.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	95,036.23	888.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	135.00	0.00
OTHER THERAPEUTIC SVC	0.00	11,191.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,108,078.93	192,363.74
MRI SERVICES	311,278.00	11,324.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	108.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	726,943.83	274,172.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,589.00

TOTAL ANCILLARY	9,127,262.39	1,092,043.01
TOTAL ACCOMODATIONS	0.00	2,440.00
TOTAL CHARGES	9,127,262.39	1,094,483.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
353	4010140065481	05/13/10 - 05/13/10	05/24/10	0.00	966.00	0.00	0.00	0.00
-1	5911022000004	10/16/10 - 10/17/10	02/21/11	0.00	613.00	0.00	0.00	0.00
3641	5911119001399	10/20/10 - 10/26/10	05/02/11	0.00	10.00	0.00	0.00	0.00
TOTAL				0.00	1,589.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	218,214.93	ADJUSTMENTS	0.00
COVERED CHARGES	178,720.30	CONTRACTUAL ALLOW	47,012.74
NON-COVERD CHARGES	39,494.63	TOTAL MEDICAID LIAB	131,707.56
		LESS: COB	131,617.56
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 116

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,470.63	94.50
MED/SURG SUPPLY	19,034.71	1,836.00
LABORATORY-GENERAL	0.00	1,487.00
RADIOLOGY-DIAGNOSTIC	4,887.00	355.00
CT SCAN	3,944.00	13,221.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,342.00	0.00
IV THERAPY	2,463.00	0.00
OPERATING ROOM	17,988.66	5,834.34
LABOR/DELIVERY ROOM	1,546.00	426.00
RESPIRATORY SERVICES	1,219.00	0.00
ANESTHESIA	5,089.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,253.00	665.00
RECOVERY ROOM	4,109.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,548.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	124.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,699.00	282.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,824.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,803.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,625.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	79.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21,844.00	3,814.00
MRI SERVICES	2,360.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,547.30	5,107.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	178,720.30	33,201.63
TOTAL ACCOMODATIONS	0.00	6,293.00
TOTAL CHARGES	178,720.30	39,494.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	511,291.15	ADJUSTMENTS	7,655.58
COVERED CHARGES	481,577.18	CONTRACTUAL ALLOW	439,901.83
NON-COVERD CHARGES	29,713.97	TOTAL MEDICAID LIAB	41,675.35
		LESS: COB	39.25
		LESS: COPAYMENT	1,413.16
		REIMBURSEMENT	40,222.94

TOTAL NUMBER OF CLAIMS 757

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,575.73	1,069.00
MED/SURG SUPPLY	5,788.71	1,020.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,276.00	0.00
CT SCAN	18,091.00	4,474.00
PHYSICAL THERAPY	2,098.00	445.00
EKG/ECG	2,806.00	0.00
IV THERAPY	1,888.00	0.00
OPERATING ROOM	1,312.00	0.00
LABOR/DELIVERY ROOM	526.00	1,004.00
RESPIRATORY SERVICES	3,389.00	166.00
ANESTHESIA	298.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	282,145.00	3,674.00
RECOVERY ROOM	179.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,908.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	249.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,462.00	3,390.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	704.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,266.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,546.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	79.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	68,589.00	6,854.00
MRI SERVICES	1,788.00	1,788.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,600.74	3,842.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	481,577.18	29,713.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	481,577.18	29,713.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,232.90	ADJUSTMENTS	0.00
COVERED CHARGES	2,831.50	CONTRACTUAL ALLOW	1,689.87
NON-COVERD CHARGES	401.40	TOTAL MEDICAID LIAB	1,141.63
		LESS: COB	1,135.63
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	416.00	78.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,380.00	251.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	72.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,831.50	401.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,831.50	401.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,795,631.48	ADJUSTMENTS	214,273.91
COVERED CHARGES	1,621,892.34	CONTRACTUAL ALLOW	1,212,415.15
NON-COVERD CHARGES	173,739.14	TOTAL MEDICAID LIAB	409,477.19
		LESS: COB	0.00
		LESS: COPAYMENT	687.00
		REIMBURSEMENT	408,790.19

TOTAL NUMBER OF CLAIMS 79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,406.41	268.09
MED/SURG SUPPLY	174,253.74	15,518.00
LABORATORY-GENERAL	0.00	150.00
RADIOLOGY-DIAGNOSTIC	17,999.00	7,346.00
CT SCAN	5,358.00	22,778.00
PHYSICAL THERAPY	1,718.00	1,724.00
EKG/ECG	854.00	244.00
IV THERAPY	19,989.00	0.00
OPERATING ROOM	171,331.80	29,477.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	70,318.00	0.00
ANESTHESIA	13,570.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,424.00	0.00
RECOVERY ROOM	4,042.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	340,762.00	42,001.00
OCCUPATIONAL THERAPY	0.00	1,920.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	992.00	512.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	496.00	346.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,938.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,499.00	4,718.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,156.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	869.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,172.00	3,072.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	702,613.39	42,795.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,621,892.34	173,739.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,621,892.34	173,739.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,149.97	ADJUSTMENTS	0.00
COVERED CHARGES	66,097.97	CONTRACTUAL ALLOW	8,739.71
NON-COVERD CHARGES	1,052.00	TOTAL MEDICAID LIAB	57,358.26
		LESS: COB	57,268.26
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SE GA HEALTH SYSTEM-BRUNSWICK
PO BOX 1518
BRUNSWICK,GA 31521-1518

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	237.00
CT SCAN	5,086.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	902.00	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	630.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,587.97	79.00
RADIOLOGY THERAPEUTIC	49,529.00	324.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	362.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	66,097.97	1,052.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,097.97	1,052.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,660,265.60	ADJUSTMENTS	369,296.71
COVERED CHARGES	11,144,924.17	CONTRACTUAL ALLOW	7,858,775.54
NON-COVERD CHARGES	515,341.43	TOTAL MEDICAID LIAB	3,286,148.63
		LESS: COB	56,114.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,230,033.66

TOTAL NUMBER OF ADMISSIONS 459

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	877	4	422,382.72	29,898.34
ROUTINE NURSERY	181	0	82,454.27	379.36
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,058	4	504,836.99	30,277.70
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	686	0	1,199,039.54	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	686	0	1,199,039.54	0.00
TOTAL ACCOMODATIONS	1,744	4	1,703,876.53	30,277.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	526,690.64	759.30
MED/SURG SUPPLY	956,515.14	2,791.92
LABORATORY-GENERAL	1,559,425.40	4,661.40
RADIOLOGY-DIAGNOSTIC	255,569.08	0.00
CT SCAN	241,418.12	412,818.16
PHYSICAL THERAPY	82,084.03	0.00
EKG/ECG	211,673.11	0.00
IV THERAPY	72,006.93	666.35
OPERATING ROOM	696,363.63	2,493.09
LABOR/DELIVERY ROOM	181,099.76	0.00
RESPIRATORY SERVICES	879,795.91	2,204.31
ANESTHESIA	148,533.84	0.00
GI SERVICES	48,559.07	0.00
EMERGENCY ROOM	363,894.37	154.76
RECOVERY ROOM	34,931.85	0.00
LABORATORY PATHOLOGIC	64,830.53	0.00
RADIOLOGY THERAPEUTIC	2,197.20	0.00
OCCUPATIONAL THERAPY	4,181.92	0.00
SPEECH PATHOLOGY	3,633.55	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 SERVICE	90,244.11	24,218.88
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,105.87	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	105,391.01	15,379.00
AUDIOLOGY	9,882.95	0.00
CARDIOLOGY	346,709.86	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,682.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,224.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	42,930.22	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	210.63
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	118,678.98	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,347,793.16	16,962.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,743.87

TOTAL ANCILLARY	9,441,047.64	485,063.73
TOTAL ACCOMODATIONS	1,703,876.53	30,277.70
TOTAL CHARGES	11,144,924.17	515,341.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011145074315	05/13/11 - 05/16/11	05/30/11	0.00	1,743.87	0.00	0.00	0.00
TOTAL				0.00	1,743.87	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,130.95	ADJUSTMENTS	0.00
COVERED CHARGES	208,635.75	CONTRACTUAL ALLOW	78,846.84
NON-COVERD CHARGES	495.20	TOTAL MEDICAID LIAB	129,788.91
		LESS: COB	129,788.91
		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	22	0	10,599.96	495.20
ROUTINE NURSERY	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	22	0	10,599.96	495.20
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	13	0	26,950.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	13	0	26,950.00	0.00
TOTAL ACCOMODATIONS	35	0	37,549.96	495.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,876.42	0.00	OTHER LAB	764.52	0.00
MED/SURG SUPPLY	4,478.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,854.41	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,989.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,073.97	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	275.84	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,475.58	0.00	MRI SERVICES	3,312.59	0.00
IV THERAPY	511.59	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,618.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,683.84	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,995.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,944.68	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,083.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	923.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	873.94	0.00	INJECTABLE DRUGS	33,773.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	540.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,169.27	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	403.92	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,618.38	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	843.29	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	171,085.79	0.00
TOTAL ACCOMODATIONS	37,549.96	495.20
TOTAL CHARGES	208,635.75	495.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,736,562.03	ADJUSTMENTS	159,378.25
COVERED CHARGES	8,891,011.24	CONTRACTUAL ALLOW	7,109,078.99
NON-COVERD CHARGES	845,550.79	TOTAL MEDICAID LIAB	1,781,932.25
		LESS: COB	4,727.13
		LESS: COPAYMENT	3,726.00
		REIMBURSEMENT	1,773,479.12
		ALL OTHER	1,638,348.20
		FEE SCHEDULE-LAB	122,714.25
		INJECTABLE DRUGS	12,416.67

TOTAL NUMBER OF CLAIMS 4,127

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,014.53	1,696.50
MED/SURG SUPPLY	246,602.10	39,786.41
LABORATORY-GENERAL	0.00	423.30
RADIOLOGY-DIAGNOSTIC	531,123.74	16,707.95
CT SCAN	1,452,179.43	142,075.66
PHYSICAL THERAPY	71,718.15	16,099.35
EKG/ECG	115,169.68	1,178.10
IV THERAPY	255,714.33	36,356.63
OPERATING ROOM	558,432.45	58,986.36
LABOR/DELIVERY ROOM	11,337.65	0.00
RESPIRATORY SERVICES	36,491.96	1,309.22
ANESTHESIA	121,724.87	6,973.80
GI SERVICES	132,742.35	12,003.21
EMERGENCY ROOM	2,045,041.38	16,977.41
RECOVERY ROOM	55,937.27	363.23
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	805.72	0.00
OCCUPATIONAL THERAPY	6,026.67	448.17
SPEECH PATHOLOGY	122.40	122.40
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	17,471.10	2,508.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	18,492.81	0.00
OTHER IMAGING SERVICE	256,402.17	46,089.48
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,488.50	7,998.11
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	290,057.59	52,074.58
AUDIOLOGY	0.00	0.00
CARDIOLOGY	205,417.62	60,421.78
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	157,663.19	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	95,441.15	1,112.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	45,748.47	254.84
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,918.63
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,376,962.07	210,783.69
MRI SERVICES	506,723.32	22,957.66
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	117,958.57	81,099.46
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	3,823.76

TOTAL ANCILLARY	8,891,011.24	845,550.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,891,011.24	845,550.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	2011228062621	08/09/11 - 08/09/11	08/22/11	0.00	3,823.76	0.00	0.00	0.00
TOTAL				0.00	3,823.76	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	197,966.70	ADJUSTMENTS	0.00
COVERED CHARGES	136,034.84	CONTRACTUAL ALLOW	67,682.57
NON-COVERD CHARGES	61,931.86	TOTAL MEDICAID LIAB	68,352.27
		LESS: COB	68,322.27
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,767.18	3,469.45
MED/SURG SUPPLY	7,673.27	2,184.05
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,316.45	0.00
CT SCAN	13,531.70	24,108.58
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,876.99	0.00
IV THERAPY	2,010.50	0.00
OPERATING ROOM	3,858.71	11,686.98
LABOR/DELIVERY ROOM	661.81	0.00
RESPIRATORY SERVICES	226.40	0.00
ANESTHESIA	3,256.91	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,624.92	334.86
RECOVERY ROOM	2,527.37	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,440.00	51.08
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,963.70	2,300.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,194.57	622.48
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,642.12	11,560.68
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/OBSERV. RM	2,896.51	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,019.36	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	379.73
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,546.37	2,950.33
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	2,283.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	136,034.84	61,931.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,034.84	61,931.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	896,264.31	ADJUSTMENTS	376.58
COVERED CHARGES	879,645.43	CONTRACTUAL ALLOW	831,425.15
NON-COVERD CHARGES	16,618.88	TOTAL MEDICAID LIAB	48,220.28
		LESS: COB	0.00
		LESS: COPAYMENT	1,692.00
		REIMBURSEMENT	46,528.28

TOTAL NUMBER OF CLAIMS 862

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,072.00	0.00
MED/SURG SUPPLY	3,124.35	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,570.46	326.73
CT SCAN	74,432.61	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,539.84	0.00
IV THERAPY	32,228.11	334.86
OPERATING ROOM	1,000.00	67.71
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,404.71	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	548,725.64	837.15
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,719.82	3,068.53
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,224.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,258.63	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	144,344.46	9,326.16
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	2,657.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	879,645.43	16,618.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	879,645.43	16,618.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,033.72	ADJUSTMENTS	0.00
COVERED CHARGES	30,238.14	CONTRACTUAL ALLOW	23,906.18
NON-COVERD CHARGES	5,795.58	TOTAL MEDICAID LIAB	6,331.96
		LESS: COB	6,298.96
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	169.95	489.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,182.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,694.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,213.70	321.30
EKG/ECG	706.86	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	812.51	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,259.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	772.62	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,072.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	363.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	61.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	965.51	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	403.92	1,663.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	880.65	0.00			

TOTAL ANCILLARY	30,238.14	5,795.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,238.14	5,795.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	365,745.43	ADJUSTMENTS	20,674.52
COVERED CHARGES	337,392.93	CONTRACTUAL ALLOW	265,921.37
NON-COVERD CHARGES	28,352.50	TOTAL MEDICAID LIAB	71,471.56
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	71,387.56

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,758.79	0.00
MED/SURG SUPPLY	45,651.11	3,497.46
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,668.03	0.00
CT SCAN	41,810.74	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,178.10	0.00
IV THERAPY	8,356.25	1,172.01
OPERATING ROOM	66,317.39	2,779.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	22,380.64	0.00
ANESTHESIA	14,737.94	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,923.67	1,355.76
RECOVERY ROOM	4,141.29	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,909.45	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,565.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,194.57	622.48
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,202.80	11,560.68
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/OBSERV. RM	8,520.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,158.17	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	733.44
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,777.33	1,772.76
MRI SERVICES	4,153.76	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	50,986.92	4,858.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	337,392.93	28,352.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	337,392.93	28,352.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
PO BOX 932085
ATLANTA,GA 31193-2085

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,794,426.20	ADJUSTMENTS	75,389.10
COVERED CHARGES	1,782,907.20	CONTRACTUAL ALLOW	909,393.66
NON-COVERD CHARGES	11,519.00	TOTAL MEDICAID LIAB	873,513.54
		LESS: COB	1,419.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	872,094.02

TOTAL NUMBER OF ADMISSIONS 260

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	366	5	192,067.00	11,353.00
ROUTINE NURSERY	153	0	67,473.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	519	5	259,540.00	11,353.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	22	0	28,534.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	22	0	28,534.00	0.00
TOTAL ACCOMODATIONS	541	5	288,074.00	11,353.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	456,081.20	0.00	OTHER LAB	3,824.00	0.00
MED/SURG SUPPLY	128,206.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	249,881.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,066.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,988.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,050.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,633.00	0.00	MRI SERVICES	4,734.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,918.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	224,884.00	166.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,891.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,855.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,224.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,813.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,264.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,349.00	0.00	INJECTABLE DRUGS	29.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,451.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	635.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,242.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,416.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,761.00	0.00			
AUDIOLOGY	11,058.00	0.00			
CARDIOLOGY	8,591.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,989.00	0.00			

TOTAL ANCILLARY	1,494,833.20	166.00
TOTAL ACCOMODATIONS	288,074.00	11,353.00
TOTAL CHARGES	1,782,907.20	11,519.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,753,307.81	ADJUSTMENTS	61,793.46
COVERED CHARGES	1,545,595.26	CONTRACTUAL ALLOW	1,145,751.13
NON-COVERD CHARGES	207,712.55	TOTAL MEDICAID LIAB	399,844.13
		LESS: COB	40.68
		LESS: COPAYMENT	2,259.00
		REIMBURSEMENT	397,544.45
		ALL OTHER	355,326.35
		FEE SCHEDULE-LAB	39,969.28
		INJECTABLE DRUGS	2,248.82

TOTAL NUMBER OF CLAIMS 1,748

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,569.00	4,435.00
MED/SURG SUPPLY	70,096.00	0.00
LABORATORY-GENERAL	0.00	227.50
RADIOLOGY-DIAGNOSTIC	87,111.00	920.00
CT SCAN	168,173.00	12,386.00
PHYSICAL THERAPY	20,401.00	18,443.00
EKG/ECG	11,342.00	31.00
IV THERAPY	27,181.00	3,862.00
OPERATING ROOM	171,956.68	39,018.32
LABOR/DELIVERY ROOM	6,662.00	0.00
RESPIRATORY SERVICES	9,501.00	1,454.00
ANESTHESIA	23,322.00	844.00
GI SERVICES	40,352.00	7,124.00
EMERGENCY ROOM	339,448.00	2,541.00
RECOVERY ROOM	26,767.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,855.00	14,092.00
SPEECH PATHOLOGY	530.00	2,373.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	256.00	64.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	47,150.00	2,144.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,366.00	1,122.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,121.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	35,125.00	3,699.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,870.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	301,078.38	57,828.73
MRI SERVICES	26,347.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	55,015.20	35,104.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,545,595.26	207,712.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,545,595.26	207,712.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	444.00	ADJUSTMENTS	0.00
COVERED CHARGES	444.00	CONTRACTUAL ALLOW	307.78
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	136.22
		LESS: COB	133.22
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	444.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	444.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	444.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,892.00	ADJUSTMENTS	329.64
COVERED CHARGES	58,542.00	CONTRACTUAL ALLOW	52,326.56
NON-COVERD CHARGES	2,350.00	TOTAL MEDICAID LIAB	6,215.44
		LESS: COB	0.00
		LESS: COPAYMENT	216.01
		REIMBURSEMENT	5,999.43

TOTAL NUMBER OF CLAIMS 112

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,614.00	19.00
MED/SURG SUPPLY	723.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	645.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	170.00	0.00
IV THERAPY	1,374.00	131.00
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	38,910.00	29.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	298.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,149.00	1,384.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,659.00	787.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	58,542.00	2,350.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,542.00	2,350.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	294,925,476.93	ADJUSTMENTS	34,813,857.51
COVERED CHARGES	287,264,626.83	CONTRACTUAL ALLOW	189,611,843.19
NON-COVERD CHARGES	7,660,850.10	TOTAL MEDICAID LIAB	97,652,783.64
		LESS: COB	291,897.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	97,360,886.26

TOTAL NUMBER OF ADMISSIONS 8,168

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	32,194	0	36,110,076.00	2,190,072.00
ROUTINE NURSERY	2,992	0	1,677,279.00	25,740.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	35,186	2	37,787,355.00	2,215,812.00
SPECIAL CARE SERVICES				
CCU	3,087	0	9,142,205.00	4,972.00
ICU	9,778	0	33,231,868.00	4,972.00
NICU	3,552	0	14,775,492.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	35	0	87,010.00	0.00
BURN UNIT	532	0	3,339,108.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	16,984	0	60,575,683.00	9,944.00
TOTAL ACCOMODATIONS	52,170	2	98,363,038.00	2,225,756.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,463,261.45	90,955.96
MED/SURG SUPPLY	17,435,485.89	815,729.09
LABORATORY-GENERAL	28,906,017.11	179,504.00
RADIOLOGY-DIAGNOSTIC	7,095,815.52	7,349.00
CT SCAN	4,995,978.00	1,487,387.00
PHYSICAL THERAPY	2,037,108.60	11,388.00
EKG/ECG	1,045,575.00	858.00
IV THERAPY	273,976.68	15,205.00
OPERATING ROOM	43,074,599.50	369,516.60
LABOR/DELIVERY ROOM	2,802,106.00	0.00
RESPIRATORY SERVICES	23,750,430.00	274,742.00
ANESTHESIA	8,229,629.00	11,276.00
GI SERVICES	445,766.00	0.00
EMERGENCY ROOM	7,832,231.00	59,170.00
RECOVERY ROOM	1,084,891.00	3,228.00
LABORATORY PATHOLOGIC	725,165.28	5,086.00
RADIOLOGY THERAPEUTIC	555,971.00	2,815.00
OCCUPATIONAL THERAPY	630,628.56	9,420.00
SPEECH PATHOLOGY	957,781.00	2,030.00
RENAL DIALYSIS	880,762.00	65,435.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,312.00	245,503.00
PSYCHIATRIC SERVICES	5,835.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,124,663.10	352,980.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,134,705.31	148,960.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	793,222.00	365,642.00
AUDIOLOGY	829,305.00	0.00
CARDIOLOGY	2,237,872.10	2,926.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	379,374.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	314,849.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	772,580.00	2,645.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	488.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,571,444.00	0.00
PROFESSIONAL FEES	0.00	352.00
DURABLE MED. EQUIP.	0.00	91.59
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	5,540.00	316.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	647.11
INJECTABLE DRUGS	11,505,220.33	56,576.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	757,466.24
NO CC/INVALID REV CODE	0.00	89,893.99

TOTAL ANCILLARY	188,901,588.83	5,435,094.10
TOTAL ACCOMODATIONS	98,363,038.00	2,225,756.00
TOTAL CHARGES	287,264,626.83	7,660,850.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
4	2211049018877	01/20/11 - 01/23/11	02/21/11	0.00	705.00	0.00	0.00	0.00
363	5911129001012	01/22/11 - 01/23/11	05/16/11	0.00	62.92	0.00	0.00	0.00
3020	2211220002379	07/21/11 - 07/23/11	08/15/11	0.00	728.00	0.00	0.00	0.00
242	2211231008836	08/10/11 - 08/12/11	08/22/11	0.00	450.00	0.00	0.00	0.00
1	5911264001441	08/10/11 - 08/13/11	09/26/11	0.00	1,347.00	0.00	0.00	0.00
4444	2211266004649	09/13/11 - 09/16/11	09/26/11	0.00	1,411.00	0.00	0.00	0.00
626	5211278000004	06/04/11 - 07/28/11	10/10/11	0.00	1,083.73	0.00	0.00	0.00
-1	2211280002735	07/26/11 - 08/02/11	10/17/11	0.00	19,828.00	0.00	0.00	0.00
2	2211287005778	09/29/11 - 10/08/11	10/17/11	0.00	176.00	0.00	0.00	0.00
3	2211314010836	10/31/11 - 11/04/11	11/14/11	0.00	249.00	0.00	0.00	0.00
15	2211315003929	08/18/11 - 08/31/11	11/14/11	0.00	61,814.00	0.00	0.00	0.00
7	5211364001329	09/29/11 - 11/03/11	01/09/12	0.00	1,413.34	0.00	0.00	0.00
3	2212041016500	12/16/11 - 12/17/11	02/13/12	0.00	193.00	0.00	0.00	0.00
308	2212118002487	12/20/11 - 12/24/11	04/30/12	0.00	433.00	0.00	0.00	0.00
TOTAL				0.00	89,893.99	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,593,055.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,584,786.50	CONTRACTUAL ALLOW	1,292,534.80
NON-COVERD CHARGES	8,268.50	TOTAL MEDICAID LIAB	292,251.70
		LESS: COB	292,251.70
		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	37	0	48,711.00	1,388.00
ROUTINE NURSERY	2	0	1,116.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	39	0	49,827.00	1,388.00
SPECIAL CARE SERVICES				
CCU	8	0	33,160.00	0.00
ICU	87	0	360,615.00	0.00
NICU	38	0	157,510.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	133	0	551,285.00	0.00
TOTAL ACCOMODATIONS	172	0	601,112.00	1,388.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,524.64	12.50
MED/SURG SUPPLY	105,270.40	910.00
LABORATORY-GENERAL	130,084.00	0.00
RADIOLOGY-DIAGNOSTIC	33,026.00	0.00
CT SCAN	4,717.00	4,762.00
PHYSICAL THERAPY	4,837.00	0.00
EKG/ECG	3,003.00	0.00
IV THERAPY	2,193.00	0.00
OPERATING ROOM	135,698.00	222.00
LABOR/DELIVERY ROOM	6,239.00	0.00
RESPIRATORY SERVICES	288,748.00	0.00
ANESTHESIA	25,949.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,711.00	0.00
RECOVERY ROOM	1,644.00	0.00
LABORATORY PATHOLOGIC	474.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,252.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	2,228.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	406.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,608.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,357.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,358.00	568.00
AUDIOLOGY	966.00	0.00
CARDIOLOGY	2,482.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	702.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,000.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,198.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	54,405.46	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	983,674.50	6,880.50
TOTAL ACCOMODATIONS	601,112.00	1,388.00
TOTAL CHARGES	1,584,786.50	8,268.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,143,310.03	ADJUSTMENTS	955,606.42
COVERED CHARGES	58,529,069.40	CONTRACTUAL ALLOW	38,499,914.27
NON-COVERD CHARGES	8,614,240.63	TOTAL MEDICAID LIAB	20,029,155.13
		LESS: COB	6,436.35
		LESS: COPAYMENT	140,259.07
		REIMBURSEMENT	19,882,459.71
		ALL OTHER	16,941,443.37
		FEE SCHEDULE-LAB	1,950,860.94
		INJECTABLE DRUGS	990,155.40

TOTAL NUMBER OF CLAIMS 69,582

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	256,206.84	50,807.79
MED/SURG SUPPLY	686,533.36	131,756.64
LABORATORY-GENERAL	0.00	1,423.50
RADIOLOGY-DIAGNOSTIC	1,981,364.90	123,309.00
CT SCAN	3,042,133.00	272,394.00
PHYSICAL THERAPY	130,376.55	18,013.00
EKG/ECG	586,497.00	33,335.00
IV THERAPY	808,648.50	115,668.00
OPERATING ROOM	2,382,994.83	1,279,471.67
LABOR/DELIVERY ROOM	153,361.00	3,523.00
RESPIRATORY SERVICES	958,469.00	69,384.00
ANESTHESIA	212,781.00	1,057.00
GI SERVICES	703,201.00	125,646.00
EMERGENCY ROOM	12,195,339.10	48,663.00
RECOVERY ROOM	77,554.00	0.00
LABORATORY PATHOLOGIC	0.00	210.00
RADIOLOGY THERAPEUTIC	1,432,544.00	10,945.00
OCCUPATIONAL THERAPY	29,274.00	6,181.00
SPEECH PATHOLOGY	16,533.00	2,854.00
RENAL DIALYSIS	0.00	18,032.00
OUTPATIENT SERVICES	175.00	0.00
CLINIC SERVICES	7,908,335.00	243,343.03
PSYCHIATRIC SERVICES	883,296.00	165,605.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,865,370.00	171,944.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	585,699.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	943,394.00	656,069.00
AUDIOLOGY	19,589.00	8,123.00
CARDIOLOGY	824,165.04	83,998.43
AMBULATORY SURGERY	0.00	3,438.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	46,393.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	152,381.08	1,554.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	666,475.00	21,902.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,011.00	87,450.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,688,266.55	3,848,064.90
MRI SERVICES	1,233,341.00	70,151.00
PROFESSIONAL FEES	0.00	495.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	9,434.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,047,933.65	710,982.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	224,302.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	58,529,069.40	8,610,095.63
TOTAL ACCOMODATIONS	0.00	4,145.00
TOTAL CHARGES	58,529,069.40	8,614,240.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,592.05	ADJUSTMENTS	0.00
COVERED CHARGES	72,274.32	CONTRACTUAL ALLOW	33,407.46
NON-COVERD CHARGES	24,317.73	TOTAL MEDICAID LIAB	38,866.86
		LESS: COB	38,751.86
		LESS: COPAYMENT	115.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84.93	142.53
MED/SURG SUPPLY	228.00	46.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,008.00	0.00
CT SCAN	3,237.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	4,638.00	864.00
OPERATING ROOM	864.00	0.00
LABOR/DELIVERY ROOM	220.00	0.00
RESPIRATORY SERVICES	412.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,041.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,048.00	0.00
OCCUPATIONAL THERAPY	0.00	657.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,150.00	1,111.00
PSYCHIATRIC SERVICES	724.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,611.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,241.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,350.00	5,480.30
MRI SERVICES	2,033.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	384.39	7,389.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	8,627.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	72,274.32	24,317.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,274.32	24,317.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,398,575.31	ADJUSTMENTS	2,649.87
COVERED CHARGES	2,264,385.14	CONTRACTUAL ALLOW	2,157,675.14
NON-COVERD CHARGES	134,190.17	TOTAL MEDICAID LIAB	106,710.00
		LESS: COB	1,676.54
		LESS: COPAYMENT	5,415.55
		REIMBURSEMENT	99,617.91

TOTAL NUMBER OF CLAIMS 1,878

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,523.04	1,324.43
MED/SURG SUPPLY	5,862.00	1,493.33
LABORATORY-GENERAL	0.00	175.00
RADIOLOGY-DIAGNOSTIC	116,485.00	3,454.00
CT SCAN	80,664.00	1,079.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	23,892.00	715.00
IV THERAPY	61,968.00	19,224.00
OPERATING ROOM	5,411.00	0.00
LABOR/DELIVERY ROOM	1,167.00	0.00
RESPIRATORY SERVICES	14,552.60	1,030.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,566,009.00	1,755.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,576.00	1,053.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,982.00	307.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,164.00	4,563.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,989.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	15,512.00	441.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	292.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	314,052.00	83,003.90
MRI SERVICES	7,889.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,687.50	14,280.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,264,385.14	134,190.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,264,385.14	134,190.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,957.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,868.00	CONTRACTUAL ALLOW	4,497.84
NON-COVERD CHARGES	89.00	TOTAL MEDICAID LIAB	2,370.16
		LESS: COB	2,361.16
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	246.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	858.00	84.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,764.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	5.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,868.00	89.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,868.00	89.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,742,025.35	ADJUSTMENTS	851,987.12
COVERED CHARGES	13,758,974.58	CONTRACTUAL ALLOW	10,110,936.97
NON-COVERD CHARGES	983,050.77	TOTAL MEDICAID LIAB	3,648,037.61
		LESS: COB	0.01
		LESS: COPAYMENT	5,702.42
		REIMBURSEMENT	3,642,335.18

TOTAL NUMBER OF CLAIMS 570

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,154.15	32,749.23
MED/SURG SUPPLY	659,337.55	260,608.48
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	423,536.00	66,260.18
CT SCAN	9,638.00	1,725.00
PHYSICAL THERAPY	0.00	3,591.00
EKG/ECG	572.00	0.00
IV THERAPY	79,783.00	0.00
OPERATING ROOM	5,774,379.71	439,766.19
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,048.00	206.00
ANESTHESIA	1,183,084.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,953.00	0.00
RECOVERY ROOM	295,346.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,189,332.00	51,647.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	519.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,556.00	175.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,971.00	1,164.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	37,877.00	1,229.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	78,063.00	12,753.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,572.13	26,707.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,400.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,374.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	174,778.45	16,873.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,691,219.59	67,076.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,758,974.58	983,050.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,758,974.58	983,050.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY HEALTH SYSTEM
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,557,678.81	ADJUSTMENTS	946,768.34
COVERED CHARGES	32,357,861.84	CONTRACTUAL ALLOW	26,081,776.17
NON-COVERD CHARGES	199,816.97	TOTAL MEDICAID LIAB	6,276,085.67
		LESS: COB	54,418.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,221,667.07

TOTAL NUMBER OF ADMISSIONS 814

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,844	101	2,909,412.00	129,502.23
ROUTINE NURSERY	195	0	151,781.03	1,261.68
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	3,039	104	3,061,193.03	130,763.91
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	696	0	1,271,169.12	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	696	0	1,271,169.12	0.00
TOTAL ACCOMODATIONS	3,735	104	4,332,362.15	130,763.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,526,050.80	1,966.80
MED/SURG SUPPLY	3,793,916.56	13,596.77
LABORATORY-GENERAL	4,227,936.71	0.00
RADIOLOGY-DIAGNOSTIC	548,925.36	0.00
CT SCAN	1,459,439.16	23,052.78
PHYSICAL THERAPY	129,056.59	0.00
EKG/ECG	257,345.54	0.00
IV THERAPY	2,274.20	0.00
OPERATING ROOM	1,022,953.40	4,326.56
LABOR/DELIVERY ROOM	286,907.95	0.00
RESPIRATORY SERVICES	3,082,515.05	4,740.81
ANESTHESIA	478,067.52	0.00
GI SERVICES	139,529.38	0.00
EMERGENCY ROOM	1,249,900.56	5,679.29
RECOVERY ROOM	141,652.62	0.00
LABORATORY PATHOLOGIC	103,306.94	0.00
RADIOLOGY THERAPEUTIC	35,707.21	0.00
OCCUPATIONAL THERAPY	27,665.00	0.00
SPEECH PATHOLOGY	29,780.60	0.00
RENAL DIALYSIS	257,685.23	3,466.62
OUTPATIENT SERVICES	529.96	0.00
CLINIC SERVICES	13,773.22	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	161,489.30	3,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	438,199.99	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	157,504.94	0.00
AUDIOLOGY	8,438.46	0.00
CARDIOLOGY	603,237.72	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	35,467.90	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	212,070.29	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	122,704.74	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	406,321.28	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	8,603.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65,145.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	119.93
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	28,025,499.69	69,053.06
TOTAL ACCOMODATIONS	4,332,362.15	130,763.91
TOTAL CHARGES	32,357,861.84	199,816.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	90,836.49	ADJUSTMENTS	0.00
COVERED CHARGES	90,678.22	CONTRACTUAL ALLOW	63,908.60
NON-COVERD CHARGES	158.27	TOTAL MEDICAID LIAB	26,769.62
		LESS: COB	26,769.62
		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	14	0	14,322.00	158.27
ROUTINE NURSERY	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	14	0	14,322.00	158.27
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	14	0	14,322.00	158.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,159.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,947.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,500.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	94.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,694.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,208.06	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,016.37	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,322.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,740.96	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,162.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,508.57	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	76,356.22	0.00
TOTAL ACCOMODATIONS	14,322.00	158.27
TOTAL CHARGES	90,678.22	158.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,299,962.83	ADJUSTMENTS	327,810.47
COVERED CHARGES	17,476,908.75	CONTRACTUAL ALLOW	14,253,911.24
NON-COVERD CHARGES	2,823,054.08	TOTAL MEDICAID LIAB	3,222,997.51
		LESS: COB	3,501.97
		LESS: COPAYMENT	5,589.00
		REIMBURSEMENT	3,213,906.54
		ALL OTHER	2,882,352.34
		FEE SCHEDULE-LAB	256,457.47
		INJECTABLE DRUGS	75,096.73

TOTAL NUMBER OF CLAIMS 6,449

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	564,264.98	25,039.01
MED/SURG SUPPLY	1,190,075.12	109,894.33
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,043,359.20	19,621.23
CT SCAN	1,786,828.51	1,003,325.19
PHYSICAL THERAPY	3,369.98	2,484.20
EKG/ECG	414,765.03	1,662.21
IV THERAPY	108,060.11	6,543.88
OPERATING ROOM	462,001.30	176,580.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	193,134.56	31,989.10
ANESTHESIA	284,875.43	0.00
GI SERVICES	114,068.41	10,192.04
EMERGENCY ROOM	4,430,948.22	32,442.26
RECOVERY ROOM	69,888.04	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	41,626.31	0.00
OCCUPATIONAL THERAPY	1,261.80	1,541.97
SPEECH PATHOLOGY	383.98	2,835.68
RENAL DIALYSIS	0.00	5,034.85
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	249,808.19	96,238.73
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	438,160.83	78,092.99
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	110,174.97	41,113.78
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	129,706.90	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	156,736.65	133,698.34
AMBULATORY SURGERY	7,949.73	2,262.01
OSTEOPATHIC SERVICES	0.00	0.00
E E G	515,743.55	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	271,465.62	213.83

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	142,271.50	915.22
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,332,152.74	492,413.09
MRI SERVICES	211,779.64	50,101.79
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	897.60
INJECTABLE DRUGS	1,202,047.45	497,920.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,476,908.75	2,823,054.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,476,908.75	2,823,054.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	284,372.86	ADJUSTMENTS	0.00
COVERED CHARGES	235,093.66	CONTRACTUAL ALLOW	169,512.04
NON-COVERD CHARGES	49,279.20	TOTAL MEDICAID LIAB	65,581.62
		LESS: COB	65,530.62
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,248.91	180.59
MED/SURG SUPPLY	12,900.51	577.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,244.62	331.09
CT SCAN	2,554.88	25,386.86
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,823.74	0.00
IV THERAPY	2,851.92	181.52
OPERATING ROOM	1,681.05	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,469.94	4,648.17
ANESTHESIA	0.00	0.00
GI SERVICES	1,430.88	0.00
EMERGENCY ROOM	54,436.62	272.28
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,818.16	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,535.64	94.92
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	346.59	2,199.66
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,822.40	266.01
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,955.18	0.00
AMBULATORY SURGERY	232.68	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,880.24	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,478.54	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,552.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36,995.29	5,420.81
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64,833.68	9,719.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	235,093.66	49,279.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	235,093.66	49,279.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,498,035.44	ADJUSTMENTS	955.89
COVERED CHARGES	1,380,690.12	CONTRACTUAL ALLOW	1,323,209.41
NON-COVERD CHARGES	117,345.32	TOTAL MEDICAID LIAB	57,480.71
		LESS: COB	0.00
		LESS: COPAYMENT	2,163.14
		REIMBURSEMENT	55,317.57

TOTAL NUMBER OF CLAIMS 1,028

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,119.98	608.81
MED/SURG SUPPLY	47,494.02	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,105.54	766.25
CT SCAN	60,125.66	54,121.74
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	23,831.57	0.00
IV THERAPY	7,005.81	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,595.91	136.60
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	760,891.71	1,860.50
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	70.80	94.92
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	27,313.78	10,681.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,551.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,747.99	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	233,891.37	33,796.96
MRI SERVICES	2,931.80	4,011.17
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65,012.90	11,266.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,380,690.12	117,345.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,380,690.12	117,345.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,524.61	ADJUSTMENTS	0.00
COVERED CHARGES	16,479.08	CONTRACTUAL ALLOW	9,578.35
NON-COVERD CHARGES	45.53	TOTAL MEDICAID LIAB	6,900.73
		LESS: COB	6,894.73
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,180.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,077.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,840.97	13.68
EKG/ECG	400.53	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,262.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	899.42	31.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	772.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,479.08	45.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,479.08	45.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	879,523.42	ADJUSTMENTS	24,241.33
COVERED CHARGES	819,835.20	CONTRACTUAL ALLOW	657,575.19
NON-COVERD CHARGES	59,688.22	TOTAL MEDICAID LIAB	162,260.01
		LESS: COB	0.00
		LESS: COPAYMENT	130.03
		REIMBURSEMENT	162,129.98

TOTAL NUMBER OF CLAIMS 33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,472.12	1,655.00
MED/SURG SUPPLY	124,696.30	5,964.61
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,794.60	7,271.04
CT SCAN	7,997.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,846.42	0.00
IV THERAPY	10,670.40	190.60
OPERATING ROOM	115,522.08	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,220.61	0.00
ANESTHESIA	63,010.48	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,356.98	281.36
RECOVERY ROOM	12,831.02	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	6,416.68	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	27.78
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,418.45	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,444.26	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	120,528.21	16,151.19
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,229.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	39,917.03	7,387.96
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	218,461.68	20,758.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	819,835.20	59,688.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	819,835.20	59,688.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,079,305.48	ADJUSTMENTS	123,273.04
COVERED CHARGES	2,071,338.49	CONTRACTUAL ALLOW	859,163.16
NON-COVERD CHARGES	7,966.99	TOTAL MEDICAID LIAB	1,212,175.33
		LESS: COB	4,840.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,207,334.44

TOTAL NUMBER OF ADMISSIONS 320

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	441	3	176,400.00	6,528.00
ROUTINE NURSERY	210	0	56,105.00	805.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	651	3	232,505.00	7,333.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	68	0	65,484.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	68	0	65,484.00	0.00
TOTAL ACCOMODATIONS	719	3	297,989.00	7,333.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322,390.86	173.55	OTHER LAB	4,619.25	0.00
MED/SURG SUPPLY	191,332.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	324,879.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,431.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,949.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,126.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,699.00	0.00	MRI SERVICES	9,028.00	0.00
IV THERAPY	112,431.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,381.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	228,075.75	0.00	REHAB THERAPY	58.25	0.00
RESPIRATORY SERVICES	41,855.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,730.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	111,782.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,365.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,566.00	0.00	INJECTABLE DRUGS	309.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	223.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	907.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	305.94
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,316.00	154.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,595.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,244.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,827.00	0.00			
AUDIOLOGY	21,432.00	0.00			
CARDIOLOGY	16,939.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,855.25	0.00			

TOTAL ANCILLARY	1,773,349.49	633.99
TOTAL ACCOMODATIONS	297,989.00	7,333.00
TOTAL CHARGES	2,071,338.49	7,966.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,063.29	ADJUSTMENTS	0.00
COVERED CHARGES	7,039.29	CONTRACTUAL ALLOW	1,328.50
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	5,710.79
		LESS: COB	5,710.79
		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	2	0	800.00	24.00
ROUTINE NURSERY	2	0	514.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,314.00	24.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,314.00	24.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	977.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	928.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,205.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	937.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	618.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	511.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	202.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	73.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,725.29	0.00
TOTAL ACCOMODATIONS	1,314.00	24.00
TOTAL CHARGES	7,039.29	24.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,426,566.02	ADJUSTMENTS	107,293.93
COVERED CHARGES	2,174,323.39	CONTRACTUAL ALLOW	1,530,277.02
NON-COVERD CHARGES	252,242.63	TOTAL MEDICAID LIAB	644,046.37
		LESS: COB	141.06
		LESS: COPAYMENT	2,202.00
		REIMBURSEMENT	641,703.31
		ALL OTHER	572,791.62
		FEE SCHEDULE-LAB	57,360.94
		INJECTABLE DRUGS	11,550.75

TOTAL NUMBER OF CLAIMS 2,223

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,471.54	11,008.28	OTHER LAB	46,901.25	0.00
MED/SURG SUPPLY	189,594.35	14,266.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115,236.00	1,349.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	268,073.00	56,444.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,191.75	4,138.25	FEE SCHEDULE LAB	410,919.00	84,347.00
EKG/ECG	24,136.00	1,900.50	MRI SERVICES	54,862.00	1,250.00
IV THERAPY	37,139.75	343.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,719.50	41,126.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,047.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,353.75	1,375.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,613.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	561,746.50	7,893.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,169.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,902.75	7,224.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,961.50	567.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,471.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	42.24
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,484.00	3,390.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	33,449.00	1,783.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,138.00	5,817.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,251.50	0.00			
AUDIOLOGY	1,413.50	0.00			
CARDIOLOGY	24,584.50	1,251.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,963.75	5,254.00			

TOTAL ANCILLARY	2,174,323.39	252,242.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,174,323.39	252,242.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,122.65	ADJUSTMENTS	0.00
COVERED CHARGES	21,186.15	CONTRACTUAL ALLOW	7,518.83
NON-COVERD CHARGES	8,936.50	TOTAL MEDICAID LIAB	13,667.32
		LESS: COB	13,658.32
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,089.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,062.69	634.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	699.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,573.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,002.00	1,266.00
EKG/ECG	0.00	103.00	MRI SERVICES	0.00	0.00
IV THERAPY	145.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,756.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,408.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,483.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	405.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	243.59	12.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	158.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	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	489.25	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,186.15	8,936.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,186.15	8,936.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	179,451.44	ADJUSTMENTS	3,239.40
COVERED CHARGES	173,472.35	CONTRACTUAL ALLOW	151,823.57
NON-COVERD CHARGES	5,979.09	TOTAL MEDICAID LIAB	21,648.78
		LESS: COB	0.00
		LESS: COPAYMENT	786.00
		REIMBURSEMENT	20,862.78

TOTAL NUMBER OF CLAIMS 387

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,236.79	12.50	OTHER LAB	628.50	0.00
MED/SURG SUPPLY	756.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,908.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,312.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,552.00	3,767.00
EKG/ECG	721.00	0.00	MRI SERVICES	0.00	1,597.00
IV THERAPY	145.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	314.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	412.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,055.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107,190.50	275.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,089.27	13.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,172.00	314.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	978.50	0.00			

TOTAL ANCILLARY	173,472.35	5,979.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	173,472.35	5,979.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,794.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,762.00	CONTRACTUAL ALLOW	1,341.50
NON-COVERD CHARGES	32.00	TOTAL MEDICAID LIAB	420.50
		LESS: COB	420.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	489.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,205.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,762.00	32.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,762.00	32.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,296.64	ADJUSTMENTS	0.00
COVERED CHARGES	13,908.64	CONTRACTUAL ALLOW	9,350.92
NON-COVERD CHARGES	1,388.00	TOTAL MEDICAID LIAB	4,557.72
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,554.72

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205.57	0.00
MED/SURG SUPPLY	10,459.82	1,388.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	558.00	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	1,378.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	704.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	331.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	270.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,908.64	1,388.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,908.64	1,388.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MED CTR
PO BOX 1629
DEMOREST,GA 30535-1629

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,600,321.54	ADJUSTMENTS	4,013,641.27
COVERED CHARGES	77,563,981.30	CONTRACTUAL ALLOW	53,164,788.30
NON-COVERD CHARGES	3,036,340.24	TOTAL MEDICAID LIAB	24,399,193.00
		LESS: COB	200,581.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,198,611.77

TOTAL NUMBER OF ADMISSIONS 3,424

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,073	44	6,994,243.00	2,508,747.00
ROUTINE NURSERY	2,319	0	1,224,232.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	11	0.00	0.00
TOTAL ROUTINE	13,392	55	8,218,475.00	2,508,747.00
SPECIAL CARE SERVICES				
CCU	381	0	577,602.00	0.00
ICU	1,254	2	1,937,720.00	3,088.00
NICU	362	0	423,540.00	0.00
PED ICU	5	0	3,970.00	0.00
NEURO ICU	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	217	0.00	155,273.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,002	219	2,942,832.00	158,361.00
TOTAL ACCOMODATIONS	15,394	274	11,161,307.00	2,667,108.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,170,857.49	26,874.45
MED/SURG SUPPLY	12,235,308.74	58,337.03
LABORATORY-GENERAL	9,320,042.22	31,229.73
RADIOLOGY-DIAGNOSTIC	1,289,803.21	2,002.32
CT SCAN	2,477,615.14	0.00
PHYSICAL THERAPY	297,868.06	1,383.08
EKG/ECG	462,553.70	231.78
IV THERAPY	105,724.41	2,490.12
OPERATING ROOM	4,752,013.07	34,167.60
LABOR/DELIVERY ROOM	1,994,393.94	0.00
RESPIRATORY SERVICES	4,220,823.30	19,604.38
ANESTHESIA	1,838,927.85	2,126.21
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,492,921.39	16,803.90
RECOVERY ROOM	1,692,509.71	2,419.68
LABORATORY PATHOLOGIC	364,303.39	1,142.65
RADIOLOGY THERAPEUTIC	191,029.76	0.00
OCCUPATIONAL THERAPY	142,435.27	566.98
SPEECH PATHOLOGY	105,089.85	483.68
RENAL DIALYSIS	379,374.95	98,021.14
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,028.40	0.00
PSYCHIATRIC SERVICES	0.00	7,066.08
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	579,869.49	936.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	672,687.86	887.06
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	373,865.77	0.00
AUDIOLOGY	93,770.96	0.00
CARDIOLOGY	2,523,113.41	2,207.17
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	122,199.92	2,084.65
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	126,535.07	137.07

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	365,145.29	844.43
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	25,777.76	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	545,628.99	9,124.80
PROFESSIONAL FEES	0.00	975.45
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	409.88	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,394,046.05	47,084.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	66,402,674.30	369,232.24
TOTAL ACCOMODATIONS	11,161,307.00	2,667,108.00
TOTAL CHARGES	77,563,981.30	3,036,340.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	725,101.29	ADJUSTMENTS	0.00
COVERED CHARGES	697,480.94	CONTRACTUAL ALLOW	268,960.25
NON-COVERD CHARGES	27,620.35	TOTAL MEDICAID LIAB	428,520.69
		LESS: COB	428,520.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	142	0	90,028.00	27,481.00
ROUTINE NURSERY	49	0	30,375.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	191	0	120,403.00	27,481.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,088.00	0.00
NICU	7	0	8,190.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	11,278.00	0.00
TOTAL ACCOMODATIONS	200	0	131,681.00	27,481.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,069.07	0.00	OTHER LAB	1,197.04	0.00
MED/SURG SUPPLY	72,841.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	73,825.92	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,834.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,632.82	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,158.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	114.39	0.00	PROFESSIONAL FEES	0.00	139.35
OPERATING ROOM	26,526.12	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	94,135.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,725.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,632.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,011.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,205.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,347.68	0.00	INJECTABLE DRUGS	36,457.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,308.21	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	409.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	11,735.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	653.07	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,788.20	0.00			
CARDIOLOGY	4,789.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	399.60	0.00			

TOTAL ANCILLARY	565,799.94	139.35
TOTAL ACCOMODATIONS	131,681.00	27,481.00
TOTAL CHARGES	697,480.94	27,620.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,059,962.77	ADJUSTMENTS	506,382.27
COVERED CHARGES	27,881,884.51	CONTRACTUAL ALLOW	22,293,837.83
NON-COVERD CHARGES	3,178,078.26	TOTAL MEDICAID LIAB	5,588,046.68
		LESS: COB	8,308.17
		LESS: COPAYMENT	13,949.91
		REIMBURSEMENT	5,565,788.60
		ALL OTHER	4,827,292.89
		FEE SCHEDULE-LAB	517,535.28
		INJECTABLE DRUGS	220,960.43

TOTAL NUMBER OF CLAIMS 13,098

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,475,895.51	1,934.71
MED/SURG SUPPLY	2,061,292.71	1,118.82
LABORATORY-GENERAL	0.00	808.27
RADIOLOGY-DIAGNOSTIC	1,469,126.47	25,310.11
CT SCAN	2,739,100.20	331,094.67
PHYSICAL THERAPY	92,393.05	36,759.07
EKG/ECG	287,400.14	13,906.78
IV THERAPY	457,968.21	54,560.52
OPERATING ROOM	2,017,899.10	814,475.16
LABOR/DELIVERY ROOM	57,281.43	0.00
RESPIRATORY SERVICES	154,662.26	7,589.97
ANESTHESIA	628,931.31	0.00
GI SERVICES	3,295.84	0.00
EMERGENCY ROOM	4,201,155.28	93,596.53
RECOVERY ROOM	747,961.05	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	864,192.77	18,592.34
OCCUPATIONAL THERAPY	14,316.07	2,582.60
SPEECH PATHOLOGY	0.00	2,536.54
RENAL DIALYSIS	0.00	1,436.07
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	8,927.20
PSYCHIATRIC SERVICES	71,544.06	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,204,893.97	156,844.21
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	55,830.20	38,029.85
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	454,465.91	6,754.51
AUDIOLOGY	2,838.67	0.00
CARDIOLOGY	505,566.07	255,909.01
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	370,830.11	7,185.15
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	618,095.77	10,144.91

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	299,405.95	3,903.03
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	248.95
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,063,481.66	907,946.45
MRI SERVICES	870,424.46	35,334.80
PROFESSIONAL FEES	0.00	325.15
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,091,636.28	335,627.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,595.12

TOTAL ANCILLARY	27,881,884.51	3,178,078.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,881,884.51	3,178,078.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3001	5911006000112	12/22/10 - 12/22/10	01/10/11	0.00	209.87	0.00	0.00	0.00
905	2011221025485	07/06/11 - 07/06/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/07/11 - 07/07/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/08/11 - 07/08/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/11/11 - 07/11/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/12/11 - 07/12/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/14/11 - 07/14/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/15/11 - 07/15/11	08/15/11	0.00	493.68	0.00	0.00	0.00
905	2011221025485	07/19/11 - 07/19/11	08/15/11	0.00	493.68	0.00	0.00	0.00
3659	5911298001224	09/06/11 - 09/06/11	10/31/11	0.00	137.07	0.00	0.00	0.00
9637	5911339000854	09/27/11 - 09/27/11	12/12/11	0.00	298.74	0.00	0.00	0.00
TOTAL				0.00	4,595.12	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	722,692.28	ADJUSTMENTS	0.00
COVERED CHARGES	647,180.72	CONTRACTUAL ALLOW	354,080.15
NON-COVERD CHARGES	75,511.56	TOTAL MEDICAID LIAB	293,100.57
		LESS: COB	292,902.57
		LESS: COPAYMENT	198.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 286

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,831.69	247.92
MED/SURG SUPPLY	56,712.24	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,065.42	447.38
CT SCAN	32,288.34	2,642.16
PHYSICAL THERAPY	1,013.44	0.00
EKG/ECG	7,357.06	231.78
IV THERAPY	8,184.16	0.00
OPERATING ROOM	69,116.92	32,457.23
LABOR/DELIVERY ROOM	2,377.41	0.00
RESPIRATORY SERVICES	1,897.28	230.91
ANESTHESIA	33,757.35	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	111,884.82	1,079.46
RECOVERY ROOM	41,407.58	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,669.21	2,456.16
OCCUPATIONAL THERAPY	313.84	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	81.90
PSYCHIATRIC SERVICES	1,766.52	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	37,798.35	3,738.72
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,657.40	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,417.82	141.41
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,700.07	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,801.42	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	131,150.74	23,349.04
MRI SERVICES	5,369.00	5,411.00
PROFESSIONAL FEES	0.00	929.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,642.64	1,726.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	647,180.72	75,171.00
TOTAL ACCOMODATIONS	0.00	340.56
TOTAL CHARGES	647,180.72	75,511.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,048,778.02	ADJUSTMENTS	1,214.59
COVERED CHARGES	987,063.72	CONTRACTUAL ALLOW	940,521.65
NON-COVERD CHARGES	61,714.30	TOTAL MEDICAID LIAB	46,542.07
		LESS: COB	92.00
		LESS: COPAYMENT	1,275.04
		REIMBURSEMENT	45,175.03

TOTAL NUMBER OF CLAIMS 832

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,906.03	247.92
MED/SURG SUPPLY	37,390.72	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,636.60	0.00
CT SCAN	43,692.64	8,318.88
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,185.18	463.56
IV THERAPY	12,617.90	0.00
OPERATING ROOM	0.00	8,837.00
LABOR/DELIVERY ROOM	322.55	0.00
RESPIRATORY SERVICES	2,680.11	230.91
ANESTHESIA	3,223.19	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	515,117.66	6,094.34
RECOVERY ROOM	1,498.68	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,213.71	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	81.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	26,100.07	452.97
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,960.17	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,886.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	184,542.12	27,713.81
MRI SERVICES	12,773.60	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,315.91	9,273.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	987,063.72	61,714.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	987,063.72	61,714.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,404.77	ADJUSTMENTS	0.00
COVERED CHARGES	28,014.71	CONTRACTUAL ALLOW	14,511.20
NON-COVERD CHARGES	390.06	TOTAL MEDICAID LIAB	13,503.51
		LESS: COB	13,476.51
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	866.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,195.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	946.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,191.04	390.06
EKG/ECG	231.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,070.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	271.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,971.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,335.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	934.68	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,014.71	390.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,014.71	390.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,512,644.18	ADJUSTMENTS	201,533.63
COVERED CHARGES	6,943,136.94	CONTRACTUAL ALLOW	5,809,808.86
NON-COVERD CHARGES	569,507.24	TOTAL MEDICAID LIAB	1,133,328.08
		LESS: COB	0.00
		LESS: COPAYMENT	3,101.74
		REIMBURSEMENT	1,130,226.34

TOTAL NUMBER OF CLAIMS 222

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	504,858.58	607.69
MED/SURG SUPPLY	1,437,862.21	490.71
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,778.39	17,201.91
CT SCAN	31,841.80	4,159.44
PHYSICAL THERAPY	0.00	627.68
EKG/ECG	18,078.84	2,317.80
IV THERAPY	177,353.05	6,640.92
OPERATING ROOM	512,686.99	246,560.69
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,685.90	0.00
ANESTHESIA	167,958.62	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,142.83	2,130.76
RECOVERY ROOM	144,593.51	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,806,414.98	15,970.94
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	331.61
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	409.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	17,341.25	0.00
OTHER IMAGING SERVICE	26,976.38	667.17
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,003.54	8,862.16
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,491.84	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	182,511.17	41,873.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	52,438.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,068.41	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	16,111.10	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	177,655.61	39,494.96
MRI SERVICES	4,236.40	3,309.60
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,509,046.68	173,061.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,788.18

TOTAL ANCILLARY	6,943,136.94	569,507.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,943,136.94	569,507.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
33	5911124000421	11/09/10 - 11/09/10	05/09/11	0.00	1,144.26	0.00	0.00	0.00
3354	5911124000607	12/20/10 - 12/20/10	05/09/11	0.00	439.49	0.00	0.00	0.00
7436	5911165000907	05/11/11 - 05/11/11	06/20/11	0.00	683.21	0.00	0.00	0.00
363	5911321000731	05/29/11 - 05/29/11	11/21/11	0.00	335.40	0.00	0.00	0.00
363	2211325008461	09/14/11 - 09/14/11	11/28/11	0.00	2,185.82	0.00	0.00	0.00
TOTAL				0.00	4,788.18	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,350.55	ADJUSTMENTS	0.00
COVERED CHARGES	27,066.69	CONTRACTUAL ALLOW	3,745.49
NON-COVERD CHARGES	21,283.86	TOTAL MEDICAID LIAB	23,321.20
		LESS: COB	23,312.20
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,329.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,783.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,041.64	2,387.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	532.39	136.36
EKG/ECG	231.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	46.45
OPERATING ROOM	0.00	18,713.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,927.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,114.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	452.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	654.36	0.00			

TOTAL ANCILLARY	27,066.69	21,283.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,066.69	21,283.86

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,116,232.71	ADJUSTMENTS	1,167,166.74
COVERED CHARGES	23,341,576.80	CONTRACTUAL ALLOW	14,868,591.06
NON-COVERD CHARGES	774,655.91	TOTAL MEDICAID LIAB	8,472,985.74
		LESS: COB	105,341.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,367,644.38

TOTAL NUMBER OF ADMISSIONS 1,643

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,891	8	3,021,311.48	451,387.76
ROUTINE NURSERY	1,330	0	1,206,986.05	3,598.16
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,221	8	4,228,297.53	454,985.92
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	550	0	1,129,215.04	0.00
NICU	123	0	256,086.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	673	0	1,385,301.04	0.00
TOTAL ACCOMODATIONS	5,894	8	5,613,598.57	454,985.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,744,323.71	3,033.35
MED/SURG SUPPLY	1,112,219.10	12,203.06
LABORATORY-GENERAL	4,448,533.35	6,404.77
RADIOLOGY-DIAGNOSTIC	448,689.03	0.00
CT SCAN	587,937.35	16,207.29
PHYSICAL THERAPY	78,793.07	0.00
EKG/ECG	171,809.19	0.00
IV THERAPY	215,205.78	12,568.96
OPERATING ROOM	2,199,092.37	11,761.44
LABOR/DELIVERY ROOM	1,282,668.70	0.00
RESPIRATORY SERVICES	1,398,498.07	1,566.48
ANESTHESIA	85,900.77	1,090.55
GI SERVICES	939.04	0.00
EMERGENCY ROOM	376,968.21	76.25
RECOVERY ROOM	217,602.73	0.00
LABORATORY PATHOLOGIC	103,962.31	0.00
RADIOLOGY THERAPEUTIC	80,017.11	0.00
OCCUPATIONAL THERAPY	35,493.81	0.00
SPEECH PATHOLOGY	23,748.79	0.00
RENAL DIALYSIS	186,215.54	14,296.80
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,740.72
PSYCHIATRIC SERVICES	294,266.41	192,709.12
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	158,148.34	5,202.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	340,479.60	22,899.77
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,130.40	9,206.71
AUDIOLOGY	45,704.18	0.00
CARDIOLOGY	373,099.36	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	73,000.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,937.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	62,753.55	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,347.33
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	318,661.43	2,754.72
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	432.83	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	223.31
INJECTABLE DRUGS	1,181,746.15	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,377.36

TOTAL ANCILLARY	17,727,978.23	319,669.99
TOTAL ACCOMODATIONS	5,613,598.57	454,985.92
TOTAL CHARGES	23,341,576.80	774,655.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2012172079715	08/03/11 - 08/05/11	06/25/12	0.00	1,377.36	0.00	0.00	0.00
TOTAL				0.00	1,377.36	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	137,822.50	ADJUSTMENTS	0.00
COVERED CHARGES	135,237.46	CONTRACTUAL ALLOW	45,623.90
NON-COVERD CHARGES	2,585.04	TOTAL MEDICAID LIAB	89,613.56
		LESS: COB	89,613.56
		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	22	0	16,977.52	2,585.04
ROUTINE NURSERY	12	0	20,448.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	34	0	37,425.52	2,585.04
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	4	0	8,328.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	8,328.00	0.00
TOTAL ACCOMODATIONS	38	0	45,753.52	2,585.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,138.25	0.00	OTHER LAB	257.35	0.00
MED/SURG SUPPLY	7,286.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,653.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	886.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	259.38	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	405.68	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,120.82	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,261.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,505.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	825.93	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	823.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,423.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,980.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,657.29	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	89,483.94	0.00
TOTAL ACCOMODATIONS	45,753.52	2,585.04
TOTAL CHARGES	135,237.46	2,585.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES	00/00/00	THROUGH 00/00/00
SERVICE DATES	10/01/10	THROUGH 09/30/11
ADMISSION DATES	00/00/00	THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,476,711.76	ADJUSTMENTS	251,729.24
COVERED CHARGES	17,216,790.00	CONTRACTUAL ALLOW	13,906,955.69
NON-COVERD CHARGES	2,259,921.76	TOTAL MEDICAID LIAB	3,309,834.31
		LESS: COB	2,165.23
		LESS: COPAYMENT	6,495.16
		REIMBURSEMENT	3,301,173.92
		ALL OTHER	2,888,674.35
		FEE SCHEDULE-LAB	319,399.61
		INJECTABLE DRUGS	93,099.96

TOTAL NUMBER OF CLAIMS 9,166

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	479,326.93	14,453.78
MED/SURG SUPPLY	483,987.50	61,353.10
LABORATORY-GENERAL	0.00	768.18
RADIOLOGY-DIAGNOSTIC	1,145,013.10	30,425.87
CT SCAN	1,388,439.62	104,151.55
PHYSICAL THERAPY	33,161.49	9,001.79
EKG/ECG	316,410.63	2,990.77
IV THERAPY	1,037,235.27	47,182.32
OPERATING ROOM	882,778.32	278,384.98
LABOR/DELIVERY ROOM	39,974.96	0.00
RESPIRATORY SERVICES	159,784.46	20,467.54
ANESTHESIA	89,315.50	762.65
GI SERVICES	1,051.71	0.00
EMERGENCY ROOM	1,822,589.45	988.63
RECOVERY ROOM	150,501.12	1,628.14
LABORATORY PATHOLOGIC	0.00	906.20
RADIOLOGY THERAPEUTIC	370,707.96	2,670.34
OCCUPATIONAL THERAPY	15,687.94	2,218.48
SPEECH PATHOLOGY	0.00	1,346.72
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	50,892.47	1,134.54
PSYCHIATRIC SERVICES	1,214.34	106.40
LITHOTRIPSY	68,276.47	0.00
OTHER IMAGING SERVICE	814,435.29	99,597.02
BLOOD	52,367.04	0.00
BLOOD STORAGE & PRO.	26,661.20	574.33
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	265,065.47	16,086.38
AUDIOLOGY	0.00	0.00
CARDIOLOGY	400,849.52	131,196.83
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	348,353.19	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	377,248.52	7,867.12

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	147,184.00	17,466.35
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,661.34	58.76
OTHER THERAPEUTIC SVC	0.00	105,484.88
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,762,414.53	1,017,997.46
MRI SERVICES	889,394.79	85,256.02
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	412.22	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	591,393.65	196,560.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	834.38

TOTAL ANCILLARY	17,216,790.00	2,259,921.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,216,790.00	2,259,921.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9928	2211054008598	11/21/10 - 11/21/10	02/28/11	0.00	410.62	0.00	0.00	0.00
3641	2211104006866	02/10/11 - 02/10/11	04/18/11	0.00	12.73	0.00	0.00	0.00
8502	2211157003582	11/08/10 - 11/08/10	06/13/11	0.00	142.07	0.00	0.00	0.00
355	2211334012159	08/02/11 - 08/02/11	12/05/11	0.00	268.96	0.00	0.00	0.00
TOTAL				0.00	834.38	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	242,875.88	ADJUSTMENTS	0.00
COVERED CHARGES	210,192.90	CONTRACTUAL ALLOW	104,173.88
NON-COVERD CHARGES	32,682.98	TOTAL MEDICAID LIAB	106,019.02
		LESS: COB	105,875.02
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 104

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,303.12	771.20	OTHER LAB	270.22	0.00
MED/SURG SUPPLY	4,557.54	32.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,232.08	0.00	OTHER THERAPEUTIC SVC	558.51	912.06
CT SCAN	15,325.37	8,945.67	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,222.04	9,584.11
EKG/ECG	2,508.75	0.00	MRI SERVICES	18,478.04	0.00
IV THERAPY	9,137.27	49.71	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,693.10	3,057.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	827.62	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	528.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,084.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,255.21	23.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,770.96	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,715.80	7,606.90
RADIOLOGY THERAPEUTIC	9,494.09	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,884.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	17,743.25	1,195.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,730.83	358.99			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,206.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,643.97	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,021.59	144.57			

TOTAL ANCILLARY	210,192.90	32,682.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	210,192.90	32,682.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,015,354.33	ADJUSTMENTS	1,247.62
COVERED CHARGES	917,784.61	CONTRACTUAL ALLOW	851,271.95
NON-COVERD CHARGES	97,569.72	TOTAL MEDICAID LIAB	66,512.66
		LESS: COB	66.77
		LESS: COPAYMENT	2,781.11
		REIMBURSEMENT	63,664.78
		TOTAL NUMBER OF CLAIMS	1,189

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,606.32	476.43	OTHER LAB	0.00	1,119.61
MED/SURG SUPPLY	8,927.84	192.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	157.11	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,079.08	1,015.39	OTHER THERAPEUTIC SVC	0.00	29,961.60
CT SCAN	37,434.16	3,750.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	645.36	FEE SCHEDULE LAB	285,077.95	36,289.41
EKG/ECG	11,303.01	0.00	MRI SERVICES	18,345.09	10,440.28
IV THERAPY	42,345.67	1,759.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,249.66	4,909.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	170.39	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,381.28	1,696.13	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,207.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	352,180.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,453.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,834.07	1,966.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	116.28	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	132.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	18,545.67	2,941.36			
BLOOD	502.02	0.00			
BLOOD STORAGE & PRO.	574.33	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,764.38	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	995.05	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,807.60	0.00			

TOTAL ANCILLARY	917,784.61	97,569.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	917,784.61	97,569.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,814.17	ADJUSTMENTS	0.00
COVERED CHARGES	5,487.87	CONTRACTUAL ALLOW	3,138.77
NON-COVERD CHARGES	326.30	TOTAL MEDICAID LIAB	2,349.10
		LESS: COB	2,340.10
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	107.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	120.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	202.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,724.48	205.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,023.46	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	232.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,763.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,487.87	326.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,487.87	326.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,956,181.43	ADJUSTMENTS	29,762.07
COVERED CHARGES	1,768,493.48	CONTRACTUAL ALLOW	1,433,486.38
NON-COVERD CHARGES	187,687.95	TOTAL MEDICAID LIAB	335,007.10
		LESS: COB	0.00
		LESS: COPAYMENT	1,171.82
		REIMBURSEMENT	333,835.28

TOTAL NUMBER OF CLAIMS 67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,825.75	308.70
MED/SURG SUPPLY	64,939.68	85,135.42
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,565.77	8,183.28
CT SCAN	82,198.55	4,664.22
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,756.45	0.00
IV THERAPY	28,499.74	0.00
OPERATING ROOM	136,191.20	2,631.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,021.51	0.00
ANESTHESIA	2,846.81	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	591.16	0.00
RECOVERY ROOM	4,763.04	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	707,345.94	12,721.70
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,483.31	612.27
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,947.12	4,954.29
BLOOD	3,428.43	0.00
BLOOD STORAGE & PRO.	1,148.66	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,783.72	2,590.05
AUDIOLOGY	0.00	0.00
CARDIOLOGY	207,422.31	23,539.27
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,793.18	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	48,037.65	10,025.50
MRI SERVICES	4,756.70	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	390,146.80	32,052.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	268.96

TOTAL ANCILLARY	1,768,493.48	187,687.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,768,493.48	187,687.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
355	2211334012239	08/23/11 - 08/23/11	12/05/11	0.00	268.96	0.00	0.00	0.00
TOTAL				0.00	268.96	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
D/B/A HAMILTON MEDICAL CENTER
DALTON,GA 30722-0000

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	612,108.73	ADJUSTMENTS	7,649.08
COVERED CHARGES	612,023.73	CONTRACTUAL ALLOW	274,023.24
NON-COVERD CHARGES	85.00	TOTAL MEDICAID LIAB	338,000.49
		LESS: COB	8,831.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	329,169.11

TOTAL NUMBER OF ADMISSIONS 50

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	153	0	58,599.00	0.00
ROUTINE NURSERY	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	153	0	58,599.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	18	0	16,434.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	18	0	16,434.00	0.00
TOTAL ACCOMODATIONS	171	0	75,033.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,531.75	0.00
MED/SURG SUPPLY	71,375.00	0.00
LABORATORY-GENERAL	94,578.00	0.00
RADIOLOGY-DIAGNOSTIC	13,028.00	0.00
CT SCAN	41,980.00	0.00
PHYSICAL THERAPY	8,214.00	0.00
EKG/ECG	4,640.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	24,946.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	43,445.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	9,788.00	0.00
EMERGENCY ROOM	39,728.11	0.00
RECOVERY ROOM	3,346.00	0.00
LABORATORY PATHOLOGIC	848.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	308.00	0.00
SPEECH PATHOLOGY	475.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,042.00	0.00
BLOOD	8,419.00	0.00
BLOOD STORAGE & PRO.	9,248.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,624.00	85.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,215.00	0.00
AMBULATORY SURGERY	7,980.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,192.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,202.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	110,837.87	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	536,990.73	85.00
TOTAL ACCOMODATIONS	75,033.00	0.00
TOTAL CHARGES	612,023.73	85.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,193,995.29	ADJUSTMENTS	154,545.00
COVERED CHARGES	1,150,047.55	CONTRACTUAL ALLOW	773,747.82
NON-COVERD CHARGES	43,947.74	TOTAL MEDICAID LIAB	376,299.73
		LESS: COB	0.00
		LESS: COPAYMENT	1,068.19
		REIMBURSEMENT	375,231.54
		ALL OTHER	337,135.62
		FEE SCHEDULE-LAB	31,843.54
		INJECTABLE DRUGS	6,252.38

TOTAL NUMBER OF CLAIMS 1,006

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,813.97	1,318.00
MED/SURG SUPPLY	83,282.50	20.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,293.00	1,672.00
CT SCAN	154,860.00	2,784.00
PHYSICAL THERAPY	1,584.00	61.00
EKG/ECG	14,355.00	0.00
IV THERAPY	23,806.00	1,261.00
OPERATING ROOM	71,973.00	1,390.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,265.00	1,733.00
ANESTHESIA	85.00	0.00
GI SERVICES	76,262.00	3,142.00
EMERGENCY ROOM	241,606.53	2,711.74
RECOVERY ROOM	19,120.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,493.00	998.00
BLOOD	645.00	0.00
BLOOD STORAGE & PRO.	544.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	40,860.00	3,164.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,077.00	0.00
AMBULATORY SURGERY	1,330.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,588.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,720.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,332.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	224,551.40	15,373.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,601.15	8,320.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,150,047.55	43,947.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,150,047.55	43,947.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,648.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,910.00	CONTRACTUAL ALLOW	375.25
NON-COVERD CHARGES	2,738.00	TOTAL MEDICAID LIAB	9,534.75
		LESS: COB	9,531.56
		LESS: COPAYMENT	3.19
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.00	128.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	314.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	204.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,013.00	2,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,583.00	39.00
EKG/ECG	435.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,450.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,064.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	177.00	170.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	353.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,910.00	2,738.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,910.00	2,738.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	76,781.92	ADJUSTMENTS	1,350.49
COVERED CHARGES	76,314.92	CONTRACTUAL ALLOW	68,763.03
NON-COVERD CHARGES	467.00	TOTAL MEDICAID LIAB	7,551.89
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	7,266.89

TOTAL NUMBER OF CLAIMS 135

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	439.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,032.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,590.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,060.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,907.00	267.00
EKG/ECG	870.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	317.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,751.92	200.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,054.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	76,314.92	467.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	76,314.92	467.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,275.37	ADJUSTMENTS	0.00
COVERED CHARGES	2,971.37	CONTRACTUAL ALLOW	837.31
NON-COVERD CHARGES	304.00	TOTAL MEDICAID LIAB	2,134.06
		LESS: COB	2,134.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,671.00	265.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,255.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	39.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,971.37	304.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,971.37	304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,210.58	ADJUSTMENTS	9,574.47
COVERED CHARGES	28,030.58	CONTRACTUAL ALLOW	18,456.11
NON-COVERD CHARGES	180.00	TOTAL MEDICAID LIAB	9,574.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,574.47

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	825.00	0.00
MED/SURG SUPPLY	737.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,130.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	11,674.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	973.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,822.00	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 SERVICE	262.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	1,330.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,536.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,940.00	180.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,801.58	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	28,030.58	180.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,030.58	180.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HART COUNTY HOSPITAL
PO BOX 280
HARTWELL,GA 30643-0280

PROVIDER NUMBER
000000921A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,447,699.03	ADJUSTMENTS	29,506,787.13
COVERED CHARGES	165,197,911.58	CONTRACTUAL ALLOW	101,754,248.75
NON-COVERD CHARGES	5,249,787.45	TOTAL MEDICAID LIAB	63,443,662.83
		LESS: COB	112,097.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	63,331,565.61

TOTAL NUMBER OF ADMISSIONS 2,754

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,710	67	10,231,165.00	3,385,665.00
ROUTINE NURSERY	1,202	0	2,023,612.00	24,713.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	9	0.00	0.00
TOTAL ROUTINE	12,912	76	12,254,777.00	3,410,378.50
SPECIAL CARE SERVICES				
CCU	1,414	0	4,492,604.00	0.00
ICU	26	0	34,008.00	0.00
NICU	1,404	0	5,975,406.00	0.00
PED ICU	4,266	20	13,592,751.00	63,520.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,110	20	24,094,769.00	63,520.00
TOTAL ACCOMODATIONS	20,022	96	36,349,546.00	3,473,898.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,559,090.55	281,445.70
MED/SURG SUPPLY	17,289,173.73	161,963.50
LABORATORY-GENERAL	21,885,248.80	176,697.00
RADIOLOGY-DIAGNOSTIC	2,996,326.50	11,653.50
CT SCAN	1,287,672.50	57,011.00
PHYSICAL THERAPY	768,342.00	2,230.00
EKG/ECG	135,470.50	2,036.50
IV THERAPY	75,229.50	8,297.00
OPERATING ROOM	13,720,884.00	25,303.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,188,818.50	72,081.50
ANESTHESIA	4,785,091.00	75,097.00
GI SERVICES	259,312.00	2,420.00
EMERGENCY ROOM	2,744,725.00	34,908.50
RECOVERY ROOM	845,893.50	20,457.50
LABORATORY PATHOLOGIC	843,392.50	4,525.50
RADIOLOGY THERAPEUTIC	689,041.00	3,270.50
OCCUPATIONAL THERAPY	310,923.50	985.00
SPEECH PATHOLOGY	412,383.50	1,169.50
RENAL DIALYSIS	74,207.50	90,919.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	71.50	55,564.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	369,901.50	81,564.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,029,079.50	4,195.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	87,804.50	3,987.00
AUDIOLOGY	40,930.00	0.00
CARDIOLOGY	3,668,430.50	1,805.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,270,029.00	3,586.50
ORGAN ACQUISITION	1,750,272.00	418,296.50
TREATMENT/OBSERV. RM	65,663.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	323,642.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	46,907.50	97,251.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,189,506.00	0.00
PROFESSIONAL FEES	0.00	12,501.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	134,902.50	188.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	64,476.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	128,848,365.58	1,775,888.95
TOTAL ACCOMODATIONS	36,349,546.00	3,473,898.50
TOTAL CHARGES	165,197,911.58	5,249,787.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,332,823.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,300,159.75	CONTRACTUAL ALLOW	1,273,095.63
NON-COVERD CHARGES	32,664.00	TOTAL MEDICAID LIAB	2,027,064.12
		LESS: COB	2,027,064.12
		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	136	0	117,821.00	25,543.00
ROUTINE NURSERY	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	136	0	117,821.00	25,543.00
SPECIAL CARE SERVICES				
CCU	19	0	60,924.00	0.00
ICU	0	0	0.00	0.00
NICU	7	0	29,680.00	0.00
PED ICU	100	0	324,270.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	126	0	414,874.00	0.00
TOTAL ACCOMODATIONS	262	0	532,695.00	25,543.00

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SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	553,044.75	0.00	OTHER LAB	4,039.00	0.00
MED/SURG SUPPLY	687,399.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	355,908.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,254.50	0.00	OTHER THERAPEUTIC SVC	67.50	1,353.00
CT SCAN	31,391.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,755.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,413.50	0.00	MRI SERVICES	2,242.50	0.00
IV THERAPY	744.00	0.00	PROFESSIONAL FEES	0.00	5,648.00
OPERATING ROOM	472,855.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	254,125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,353.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,971.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,225.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,607.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,293.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,522.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,269.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,602.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,047.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	155.50	0.00			
CARDIOLOGY	67,465.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,409.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	304.00	0.00			

TOTAL ANCILLARY	2,767,464.75	7,121.00
TOTAL ACCOMODATIONS	532,695.00	25,543.00
TOTAL CHARGES	3,300,159.75	32,664.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,920,910.71	ADJUSTMENTS	2,409,363.75
COVERED CHARGES	38,373,058.70	CONTRACTUAL ALLOW	25,709,826.89
NON-COVERD CHARGES	2,547,852.01	TOTAL MEDICAID LIAB	12,663,231.81
		LESS: COB	85,446.83
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	12,577,673.98
		ALL OTHER	11,205,033.02
		FEE SCHEDULE-LAB	604,520.37
		INJECTABLE DRUGS	768,120.59

TOTAL NUMBER OF CLAIMS 17,982

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,897,991.26	13,825.50
MED/SURG SUPPLY	2,219,267.27	6,681.75
LABORATORY-GENERAL	0.00	882.23
RADIOLOGY-DIAGNOSTIC	1,304,907.00	26,454.50
CT SCAN	1,168,553.50	79,378.00
PHYSICAL THERAPY	92,927.00	3,370.50
EKG/ECG	368,396.00	0.00
IV THERAPY	683,201.00	13,813.00
OPERATING ROOM	3,646,047.53	321,410.47
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	525,860.70	12,650.50
ANESTHESIA	2,034,515.00	0.00
GI SERVICES	290,575.50	4,229.00
EMERGENCY ROOM	3,882,890.50	19,310.50
RECOVERY ROOM	988,290.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	992,184.00	10,352.50
OCCUPATIONAL THERAPY	36,762.50	1,073.50
SPEECH PATHOLOGY	287,515.00	862.00
RENAL DIALYSIS	0.00	2,089.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,199,129.00	26,344.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	369,241.00	63,027.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	599,865.50	7,344.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	276,548.50	37,571.50
AUDIOLOGY	147,576.00	1,393.00
CARDIOLOGY	1,040,128.65	75,293.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,287,339.50	0.00
ORGAN ACQUISITION	0.00	69,955.50
TREATMENT/OBSERV. RM	459,489.50	19,746.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	326,300.00	1,432.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	529.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,261,102.79	1,251,580.81
MRI SERVICES	2,540,715.50	258,865.50
PROFESSIONAL FEES	0.00	14,460.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	3,737.00	0.00
INJECTABLE DRUGS	2,442,001.50	182,093.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	408.75
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	21,424.50
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	38,373,058.70	2,547,852.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,373,058.70	2,547,852.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,208,807.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,686,370.10	CONTRACTUAL ALLOW	420,659.92
NON-COVERD CHARGES	522,437.00	TOTAL MEDICAID LIAB	1,265,710.18
		LESS: COB	1,265,680.18
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 738

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,872.50	2,477.75
MED/SURG SUPPLY	153,130.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,969.50	2,299.00
CT SCAN	26,167.50	19,655.50
PHYSICAL THERAPY	2,490.00	492.50
EKG/ECG	13,695.00	0.00
IV THERAPY	9,768.00	0.00
OPERATING ROOM	149,116.00	178,565.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,647.50	539.50
ANESTHESIA	161,369.00	0.00
GI SERVICES	19,466.00	3,425.00
EMERGENCY ROOM	148,910.50	572.50
RECOVERY ROOM	77,099.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	27,252.50	4,649.50
OCCUPATIONAL THERAPY	3,200.00	0.00
SPEECH PATHOLOGY	6,156.50	10,943.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37,300.50	191.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,271.50	9,976.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,701.00	17,235.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,982.50	685.50
AUDIOLOGY	3,926.00	4,585.00
CARDIOLOGY	36,035.00	75,062.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,511.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,384.50	912.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,374.00	358.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	319,048.10	46,702.50
MRI SERVICES	73,568.00	71,227.50
PROFESSIONAL FEES	0.00	53,070.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	132,957.25	18,068.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	742.50
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,686,370.10	522,437.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,686,370.10	522,437.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	915,404.25	ADJUSTMENTS	1,901.95
COVERED CHARGES	872,600.50	CONTRACTUAL ALLOW	818,629.02
NON-COVERD CHARGES	42,803.75	TOTAL MEDICAID LIAB	53,971.48
		LESS: COB	201.23
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	53,761.25

TOTAL NUMBER OF CLAIMS 962

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,073.25	34.75
MED/SURG SUPPLY	24,343.25	759.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,501.00	824.00
CT SCAN	10,233.00	0.00
PHYSICAL THERAPY	2,401.50	0.00
EKG/ECG	4,220.00	0.00
IV THERAPY	284.50	0.00
OPERATING ROOM	20,916.50	2,747.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,668.00	0.00
ANESTHESIA	7,202.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	518,203.00	0.00
RECOVERY ROOM	2,242.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	497.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	879.00	1,534.50
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	0.00	0.00
OTHER IMAGING SERVICE	10,155.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	451.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,973.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	895.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,956.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,193.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	67.50	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	135,239.00	33,529.50
MRI SERVICES	4,764.00	0.00
PROFESSIONAL FEES	0.00	3,236.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,121.00	138.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	872,600.50	42,803.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	872,600.50	42,803.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,876.75	ADJUSTMENTS	0.00
COVERED CHARGES	35,221.75	CONTRACTUAL ALLOW	11,928.89
NON-COVERD CHARGES	8,655.00	TOTAL MEDICAID LIAB	23,292.86
		LESS: COB	23,292.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,367.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	156.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,073.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,619.50	712.50
EKG/ECG	211.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	7,635.50
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,436.00	307.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,200.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	516.50	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	3,543.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,221.75	8,655.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,221.75	8,655.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,902,941.70	ADJUSTMENTS	885,412.03
COVERED CHARGES	14,628,013.37	CONTRACTUAL ALLOW	11,497,010.68
NON-COVERD CHARGES	1,274,928.33	TOTAL MEDICAID LIAB	3,131,002.69
		LESS: COB	274,687.57
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	2,856,306.12

TOTAL NUMBER OF CLAIMS 405

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	687,041.00	807.50
MED/SURG SUPPLY	5,919,816.77	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	478,339.50	113,414.00
CT SCAN	35,311.50	8,640.00
PHYSICAL THERAPY	9,462.00	8,191.00
EKG/ECG	13,902.00	0.00
IV THERAPY	125,097.00	6,219.50
OPERATING ROOM	1,983,369.07	253,680.93
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	38,096.50	1,780.50
ANESTHESIA	1,195,073.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,599.00	482.00
RECOVERY ROOM	258,753.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,369.50	1,464.50
OCCUPATIONAL THERAPY	0.00	1,400.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,091.00	6,240.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	45,873.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,542.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,624.00	1,688.00
AUDIOLOGY	6,269.00	0.00
CARDIOLOGY	2,674,937.00	668,136.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,591.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	151,676.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,358.50	358.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	264.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	480,789.03	161,089.40
MRI SERVICES	241,115.50	12,935.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	157,917.50	28,137.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,628,013.37	1,274,928.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,628,013.37	1,274,928.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	398,764.54	ADJUSTMENTS	0.00
COVERED CHARGES	348,129.04	CONTRACTUAL ALLOW	92,767.23
NON-COVERD CHARGES	50,635.50	TOTAL MEDICAID LIAB	255,361.81
		LESS: COB	255,361.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,214.25	1,078.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	120,306.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,431.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,624.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	247.00	FEE SCHEDULE LAB	10,454.50	1,979.50
EKG/ECG	0.00	0.00	MRI SERVICES	18,646.00	0.00
IV THERAPY	1,506.00	0.00	PROFESSIONAL FEES	0.00	235.00
OPERATING ROOM	46,179.00	19,689.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,399.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,555.00	337.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,817.75	1,367.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,398.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,946.50	24,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,180.00	0.00			

TOTAL ANCILLARY	348,129.04	50,635.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	348,129.04	50,635.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,301,582.86	ADJUSTMENTS	6,161.21
COVERED CHARGES	1,292,507.86	CONTRACTUAL ALLOW	896,976.67
NON-COVERD CHARGES	9,075.00	TOTAL MEDICAID LIAB	395,531.19
		LESS: COB	7,909.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	387,621.40

TOTAL NUMBER OF ADMISSIONS 64

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	99	0	82,863.00	7,107.00
ROUTINE NURSERY	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	99	0	82,863.00	7,107.00
SPECIAL CARE SERVICES				
CCU	85	0	111,582.00	0.00
ICU	49	0	103,880.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	134	0	215,462.00	0.00
TOTAL ACCOMODATIONS	233	0	298,325.00	7,107.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,859.07	0.00	OTHER LAB	7,114.00	0.00
MED/SURG SUPPLY	86,663.51	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	287,174.00	0.00	EDUCATION & TRAINING	84.00	0.00
RADIOLOGY-DIAGNOSTIC	28,145.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,100.00	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,901.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,881.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,691.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,598.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,322.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,679.00	0.00	INJECTABLE DRUGS	69,953.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	552.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,580.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,120.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,861.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,773.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,495.00	0.00			

TOTAL ANCILLARY	994,182.86	1,968.00
TOTAL ACCOMODATIONS	298,325.00	7,107.00
TOTAL CHARGES	1,292,507.86	9,075.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,164,627.97	ADJUSTMENTS	180,267.74
COVERED CHARGES	3,819,108.30	CONTRACTUAL ALLOW	2,647,775.39
NON-COVERD CHARGES	345,519.67	TOTAL MEDICAID LIAB	1,171,332.91
		LESS: COB	2,556.41
		LESS: COPAYMENT	4,059.00
		REIMBURSEMENT	1,164,717.50
		ALL OTHER	1,089,062.85
		FEE SCHEDULE-LAB	70,771.28
		INJECTABLE DRUGS	4,883.37

TOTAL NUMBER OF CLAIMS 2,631

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,586.34	2,678.21
MED/SURG SUPPLY	171,701.76	1,553.50
LABORATORY-GENERAL	0.00	684.00
RADIOLOGY-DIAGNOSTIC	237,223.00	10,663.00
CT SCAN	629,921.00	78,100.00
PHYSICAL THERAPY	89,023.00	4,411.00
EKG/ECG	49,286.00	1,000.00
IV THERAPY	42,662.11	1,918.93
OPERATING ROOM	213,411.50	33,353.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	35,582.00	7,730.00
ANESTHESIA	0.00	0.00
GI SERVICES	96,800.00	13,986.00
EMERGENCY ROOM	753,379.86	7,565.30
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	295.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,886.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	23,500.00	0.00
OTHER IMAGING SERVICE	80,730.00	2,913.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,950.00	1,140.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	85,810.00	10,638.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	51,261.00	716.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,830.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	58,500.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,620.00	620.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	737,326.00	128,469.80
MRI SERVICES	239,520.00	9,080.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,484.73	26,076.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	42.00

TOTAL ANCILLARY	3,819,108.30	345,519.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,819,108.30	345,519.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
536	4010250068344	07/08/10 - 07/08/10	09/13/10	0.00	21.00	0.00	0.00	0.00
3250	4010250068410	08/22/10 - 08/22/10	09/13/10	0.00	21.00	0.00	0.00	0.00
TOTAL				0.00	42.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,407.57	ADJUSTMENTS	0.00
COVERED CHARGES	12,426.57	CONTRACTUAL ALLOW	11,400.16
NON-COVERD CHARGES	981.00	TOTAL MEDICAID LIAB	1,026.41
		LESS: COB	1,026.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	258.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	570.00	195.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,600.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,187.00	786.00
EKG/ECG	400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	46.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	65.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,426.57	981.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,426.57	981.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,186.10	ADJUSTMENTS	291.00
COVERED CHARGES	159,597.11	CONTRACTUAL ALLOW	146,317.09
NON-COVERD CHARGES	3,588.99	TOTAL MEDICAID LIAB	13,280.02
		LESS: COB	0.00
		LESS: COPAYMENT	501.01
		REIMBURSEMENT	12,779.01

TOTAL NUMBER OF CLAIMS 266

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,115.71	0.00
MED/SURG SUPPLY	1,395.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,600.00	0.00
CT SCAN	4,750.00	1,550.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	800.00	0.00
IV THERAPY	812.50	0.00
OPERATING ROOM	0.00	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	89,628.04	282.46
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,640.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	620.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,611.00	1,089.00
MRI SERVICES	2,840.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,150.86	667.53
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	159,597.11	3,588.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,597.11	3,588.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,165.18	ADJUSTMENTS	0.00
COVERED CHARGES	1,147.18	CONTRACTUAL ALLOW	1,144.18
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	313.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	588.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,147.18	18.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,147.18	18.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	449,397.27	ADJUSTMENTS	55,705.76
COVERED CHARGES	422,046.96	CONTRACTUAL ALLOW	319,787.20
NON-COVERD CHARGES	27,350.31	TOTAL MEDICAID LIAB	102,259.76
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	102,067.76

TOTAL NUMBER OF CLAIMS 22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,935.83	0.00
MED/SURG SUPPLY	116,848.05	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,215.00	195.00
CT SCAN	2,200.00	1,600.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,800.00	0.00
IV THERAPY	11,592.00	230.00
OPERATING ROOM	58,620.00	4,800.00
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	2,684.00	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	141,000.00	11,750.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	628.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,034.00	603.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,465.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,762.00	4,207.90
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,291.08	3,336.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	422,046.96	27,350.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	422,046.96	27,350.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,761,805.43	ADJUSTMENTS	967,680.47
COVERED CHARGES	17,538,989.35	CONTRACTUAL ALLOW	10,680,928.44
NON-COVERD CHARGES	1,222,816.08	TOTAL MEDICAID LIAB	6,858,060.91
		LESS: COB	110,228.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,747,832.52

TOTAL NUMBER OF ADMISSIONS 1,294

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,387	0	2,700,735.00	1,142,065.00
ROUTINE NURSERY	525	0	293,867.00	342.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,912	0	2,994,602.00	1,142,407.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	478	0	690,318.00	0.00
NICU	35	0	66,360.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	513	0	756,678.00	0.00
TOTAL ACCOMODATIONS	5,425	0	3,751,280.00	1,142,407.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,575,398.88	10,122.68
MED/SURG SUPPLY	982,919.51	11,656.08
LABORATORY-GENERAL	2,850,196.47	8,070.24
RADIOLOGY-DIAGNOSTIC	427,913.08	223.31
CT SCAN	1,216,106.16	3,182.44
PHYSICAL THERAPY	89,780.90	255.54
EKG/ECG	193,781.11	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	773,257.62	8,724.09
LABOR/DELIVERY ROOM	979,140.12	0.00
RESPIRATORY SERVICES	641,681.71	5,740.72
ANESTHESIA	83,320.71	627.99
GI SERVICES	0.00	0.00
EMERGENCY ROOM	589,906.29	2,544.22
RECOVERY ROOM	130,176.74	1,149.52
LABORATORY PATHOLOGIC	66,200.29	228.27
RADIOLOGY THERAPEUTIC	1,096.78	0.00
OCCUPATIONAL THERAPY	31,566.64	1,600.94
SPEECH PATHOLOGY	20,312.32	0.00
RENAL DIALYSIS	75,465.18	15,867.53
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,701.81	1,365.42
PSYCHIATRIC SERVICES	16,000.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	241,311.14	711.93
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	184,317.19	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	110,893.09	82.67
AUDIOLOGY	476.00	0.00
CARDIOLOGY	836,187.25	1,501.71
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,443.84	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	163,599.75	123.48

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	106,241.93	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,011.86	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	364,304.98	2,513.88
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	736.28
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	3,380.14

TOTAL ANCILLARY	13,787,709.35	80,409.08
TOTAL ACCOMODATIONS	3,751,280.00	1,142,407.00
TOTAL CHARGES	17,538,989.35	1,222,816.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
5170	5911147001061	04/08/11 - 04/12/11	05/30/11	0.00	400.05	0.00	0.00	0.00
615	9112025005533	10/31/11 - 11/09/11	02/27/12	0.00	2,980.09	0.00	1,565.40	0.00
TOTAL				0.00	3,380.14	0.00	1,565.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	150,177.96	ADJUSTMENTS	0.00
COVERED CHARGES	133,576.56	CONTRACTUAL ALLOW	58,308.16
NON-COVERD CHARGES	16,601.40	TOTAL MEDICAID LIAB	75,268.40
		LESS: COB	75,268.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	48	0	29,370.00	16,542.00
ROUTINE NURSERY	2	0	1,100.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	50	0	30,470.00	16,542.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	4,785.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,785.00	0.00
TOTAL ACCOMODATIONS	55	0	35,255.00	16,542.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,982.51	0.00
MED/SURG SUPPLY	3,204.83	0.00
LABORATORY-GENERAL	23,896.52	0.00
RADIOLOGY-DIAGNOSTIC	3,267.69	0.00
CT SCAN	16,375.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,613.88	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,325.74	0.00
LABOR/DELIVERY ROOM	8,829.04	0.00
RESPIRATORY SERVICES	5,209.42	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,186.24	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	398.40	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	15.09	0.00
PSYCHIATRIC SERVICES	125.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	711.93	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	1,501.71	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,181.12	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	944.61	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,552.23	0.00
PROFESSIONAL FEES	0.00	59.40
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	98,321.56	59.40
TOTAL ACCOMODATIONS	35,255.00	16,542.00
TOTAL CHARGES	133,576.56	16,601.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,538,441.53	ADJUSTMENTS	661,375.23
COVERED CHARGES	11,041,403.99	CONTRACTUAL ALLOW	8,390,236.75
NON-COVERD CHARGES	1,497,037.54	TOTAL MEDICAID LIAB	2,651,167.24
		LESS: COB	11,160.52
		LESS: COPAYMENT	9,698.25
		REIMBURSEMENT	2,630,308.47
		ALL OTHER	2,256,096.87
		FEE SCHEDULE-LAB	232,431.40
		INJECTABLE DRUGS	141,780.20

TOTAL NUMBER OF CLAIMS 7,045

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,119.38	2,758.51
MED/SURG SUPPLY	377,958.69	21,390.42
LABORATORY-GENERAL	0.00	257.99
RADIOLOGY-DIAGNOSTIC	725,007.42	14,627.60
CT SCAN	1,533,595.56	414,790.30
PHYSICAL THERAPY	19,449.33	15,275.74
EKG/ECG	138,510.56	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,335,740.58	138,676.43
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50,795.64	15,395.69
ANESTHESIA	145,341.38	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,808,769.38	11,350.16
RECOVERY ROOM	333,382.87	0.00
LABORATORY PATHOLOGIC	0.00	273.50
RADIOLOGY THERAPEUTIC	23,160.06	89.47
OCCUPATIONAL THERAPY	14,865.28	10,293.78
SPEECH PATHOLOGY	11,581.65	8,412.14
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,537.61	2,141.49
PSYCHIATRIC SERVICES	18,125.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	464,400.75	71,769.73
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,435.22	800.78
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	91,867.99	360.81
AUDIOLOGY	0.00	0.00
CARDIOLOGY	264,677.94	108,029.96
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,805.02	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	362,362.52	8,400.45

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	214,394.86	1,051.40
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,618.90	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,835,569.99	367,223.70
MRI SERVICES	334,532.41	23,777.32
PROFESSIONAL FEES	0.00	528.00
DURABLE MED. EQUIP.	0.00	131.22
REHAB THERAPY	2,084.61	3,790.20
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	700,713.39	255,315.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,041,403.99	1,496,912.22
TOTAL ACCOMODATIONS	0.00	125.32
TOTAL CHARGES	11,041,403.99	1,497,037.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	475,785.30	ADJUSTMENTS	0.00
COVERED CHARGES	319,120.39	CONTRACTUAL ALLOW	49,699.77
NON-COVERD CHARGES	156,664.91	TOTAL MEDICAID LIAB	269,420.62
		LESS: COB	269,186.07
		LESS: COPAYMENT	234.55
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 257

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,452.77	0.00
MED/SURG SUPPLY	19,365.02	430.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,737.01	296.72
CT SCAN	24,864.53	31,618.85
PHYSICAL THERAPY	222.30	0.00
EKG/ECG	1,477.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	57,037.96	43,363.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,153.91	309.90
ANESTHESIA	10,509.59	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	48,392.90	895.58
RECOVERY ROOM	23,166.12	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	88.34	0.00
OCCUPATIONAL THERAPY	0.00	1,427.56
SPEECH PATHOLOGY	0.00	635.89
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	103.14
PSYCHIATRIC SERVICES	125.00	125.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,219.37	14,620.03
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	925.60	490.32
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,003.42	8,874.58
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	727.04	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,897.87	334.58

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,982.18	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	231.12	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	56,980.33	11,354.07
MRI SERVICES	9,104.46	7,336.43
PROFESSIONAL FEES	0.00	284.40
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,456.55	34,027.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	136.04

TOTAL ANCILLARY	319,120.39	156,664.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	319,120.39	156,664.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
701	1111301005702	09/20/11 - 09/20/11	11/21/11	0.00	136.04	0.00	1,766.81	0.00
TOTAL				0.00	136.04	0.00	1,766.81	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	457,612.59	ADJUSTMENTS	5,396.05
COVERED CHARGES	423,836.20	CONTRACTUAL ALLOW	383,275.15
NON-COVERD CHARGES	33,776.39	TOTAL MEDICAID LIAB	40,561.05
		LESS: COB	5.74
		LESS: COPAYMENT	1,356.12
		REIMBURSEMENT	39,199.19

TOTAL NUMBER OF CLAIMS 737

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,938.21	0.00
MED/SURG SUPPLY	1,082.45	360.98
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,906.58	0.00
CT SCAN	22,999.76	16,009.80
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,385.48	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	471.00	413.20
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	253,650.70	82.93
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	2,125.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,540.34	907.57
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	462.99	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,729.09	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	79,071.22	15,193.55
MRI SERVICES	2,969.53	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,503.85	808.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	423,836.20	33,776.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	423,836.20	33,776.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,699.36	ADJUSTMENTS	0.00
COVERED CHARGES	16,173.03	CONTRACTUAL ALLOW	1,781.50
NON-COVERD CHARGES	7,526.33	TOTAL MEDICAID LIAB	14,391.53
		LESS: COB	14,358.53
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	929.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,897.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,623.39	346.37
EKG/ECG	159.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,209.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.30	57.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	3,225.95			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,173.03	7,526.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,173.03	7,526.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	942,687.51	ADJUSTMENTS	77,233.76
COVERED CHARGES	921,999.65	CONTRACTUAL ALLOW	705,721.43
NON-COVERD CHARGES	20,687.86	TOTAL MEDICAID LIAB	216,278.22
		LESS: COB	0.00
		LESS: COPAYMENT	495.38
		REIMBURSEMENT	215,782.84

TOTAL NUMBER OF CLAIMS 46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,617.62	246.85
MED/SURG SUPPLY	17,550.77	380.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,555.01	0.00
CT SCAN	6,098.23	5,748.16
PHYSICAL THERAPY	0.00	202.77
EKG/ECG	3,246.84	0.00
IV THERAPY	618.38	24.98
OPERATING ROOM	98,509.86	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,181.13	458.58
ANESTHESIA	711.11	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,682.42	0.00
RECOVERY ROOM	17,338.81	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	12,408.68	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	490.32	42.18
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	925.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	573.65	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	91,362.58	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	727.04	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	28,088.91	576.98

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,525.75	5,866.34
MRI SERVICES	2,969.53	5,242.47
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	594,817.41	1,897.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	921,999.65	20,687.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,999.65	20,687.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,072,439.04	ADJUSTMENTS	20,531.06
COVERED CHARGES	1,987,876.81	CONTRACTUAL ALLOW	889,612.17
NON-COVERD CHARGES	84,562.23	TOTAL MEDICAID LIAB	1,098,264.64
		LESS: COB	2,581.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,095,683.58

TOTAL NUMBER OF ADMISSIONS 329

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	613	0	198,950.00	54,775.00
ROUTINE NURSERY	228	0	75,750.00	14,250.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	841	0	274,700.00	69,025.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1	0	1,850.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	1,850.00	0.00
TOTAL ACCOMODATIONS	842	0	276,550.00	69,025.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298,812.10	0.00
MED/SURG SUPPLY	189,948.65	0.00
LABORATORY-GENERAL	168,447.96	0.00
RADIOLOGY-DIAGNOSTIC	11,304.90	0.00
CT SCAN	41,410.50	0.00
PHYSICAL THERAPY	100.80	0.00
EKG/ECG	13,833.00	0.00
IV THERAPY	4,230.00	0.00
OPERATING ROOM	473,351.09	0.00
LABOR/DELIVERY ROOM	310,304.25	0.00
RESPIRATORY SERVICES	36,464.49	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,614.81	0.00
EMERGENCY ROOM	23,009.00	0.00
RECOVERY ROOM	23,600.00	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 SERVICE	21,120.70	0.00
BLOOD	8,107.01	6,266.15
BLOOD STORAGE & PRO.	7,990.86	850.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	5,085.00	0.00
CARDIOLOGY	4,092.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,100.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,316.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,438.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,186.85	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	2,045.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	300.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,413.84	8,121.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,711,326.81	15,537.23
TOTAL ACCOMODATIONS	276,550.00	69,025.00
TOTAL CHARGES	1,987,876.81	84,562.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,442.27	ADJUSTMENTS	0.00
COVERED CHARGES	7,442.27	CONTRACTUAL ALLOW	2,065.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,377.09
		LESS: COB	5,377.09
		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	3	0	975.00	0.00
ROUTINE NURSERY	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	975.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	975.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	918.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	524.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	528.56	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,172.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	240.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,467.27	0.00
TOTAL ACCOMODATIONS	975.00	0.00
TOTAL CHARGES	7,442.27	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,137,132.60	ADJUSTMENTS	41,280.77
COVERED CHARGES	1,904,436.05	CONTRACTUAL ALLOW	1,453,187.16
NON-COVERD CHARGES	232,696.55	TOTAL MEDICAID LIAB	451,248.89
		LESS: COB	23.37
		LESS: COPAYMENT	1,218.00
		REIMBURSEMENT	450,007.52
		ALL OTHER	408,363.02
		FEE SCHEDULE-LAB	38,576.86
		INJECTABLE DRUGS	3,067.64

TOTAL NUMBER OF CLAIMS 922

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,741.24	16,409.78
MED/SURG SUPPLY	66,011.75	158.21
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,863.30	731.90
CT SCAN	45,221.00	14,095.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	26,394.00	159.00
IV THERAPY	147,410.00	3,140.00
OPERATING ROOM	806,023.70	59,049.45
LABOR/DELIVERY ROOM	9,132.50	0.00
RESPIRATORY SERVICES	21,415.32	342.39
ANESTHESIA	0.00	0.00
GI SERVICES	4,614.81	0.00
EMERGENCY ROOM	110,489.00	300.00
RECOVERY ROOM	40,000.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	350.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,430.29	8,818.60
BLOOD	613.62	1,840.86
BLOOD STORAGE & PRO.	0.00	1,350.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,092.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	25.00
TREATMENT/OBSERV. RM	166,742.00	40,363.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,426.00	600.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	20.00	1,174.43
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	227,308.82	64,566.27
MRI SERVICES	7,660.00	3,680.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,826.70	15,542.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,904,436.05	232,696.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,904,436.05	232,696.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	664.71	ADJUSTMENTS	0.00
COVERED CHARGES	458.76	CONTRACTUAL ALLOW	294.78
NON-COVERD CHARGES	205.95	TOTAL MEDICAID LIAB	163.98
		LESS: COB	163.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	383.76	205.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	458.76	205.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	458.76	205.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,487.30	ADJUSTMENTS	0.00
COVERED CHARGES	41,564.01	CONTRACTUAL ALLOW	36,373.45
NON-COVERD CHARGES	2,923.29	TOTAL MEDICAID LIAB	5,190.56
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	5,037.56

TOTAL NUMBER OF CLAIMS 93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,026.18	0.00	OTHER LAB	534.00	672.00
MED/SURG SUPPLY	377.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,034.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	714.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,311.36	532.13
EKG/ECG	159.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,175.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,496.44	112.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	571.00	246.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,007.00	1,360.00			

TOTAL ANCILLARY	41,564.01	2,923.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,564.01	2,923.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	106,993.94	ADJUSTMENTS	0.00
COVERED CHARGES	105,051.43	CONTRACTUAL ALLOW	80,781.74
NON-COVERD CHARGES	1,942.51	TOTAL MEDICAID LIAB	24,269.69
		LESS: COB	0.00
		LESS: COPAYMENT	26.72
		REIMBURSEMENT	24,242.97

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,724.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,619.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,134.12	1,241.42
EKG/ECG	159.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,282.82	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	240.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,284.54	331.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	267.00	369.60			
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/OBSERV. RM	290.00	0.00			

TOTAL ANCILLARY	105,051.43	1,942.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,051.43	1,942.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,094.76	ADJUSTMENTS	0.00
COVERED CHARGES	13,040.76	CONTRACTUAL ALLOW	2,898.59
NON-COVERD CHARGES	54.00	TOTAL MEDICAID LIAB	10,142.17
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,142.17

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	1,801.75	27.00
ROUTINE NURSERY	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	1,801.75	27.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	1,801.75	27.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,048.95	0.00
MED/SURG SUPPLY	1,562.17	0.00
LABORATORY-GENERAL	4,001.90	0.00
RADIOLOGY-DIAGNOSTIC	520.95	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	605.47	0.00
IV THERAPY	536.26	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	101.16	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,308.09	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	27.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,554.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,239.01	27.00
TOTAL ACCOMODATIONS	1,801.75	27.00
TOTAL CHARGES	13,040.76	54.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	385,030.56	ADJUSTMENTS	9,824.60
COVERED CHARGES	321,314.89	CONTRACTUAL ALLOW	142,877.20
NON-COVERD CHARGES	63,715.67	TOTAL MEDICAID LIAB	178,437.69
		LESS: COB	0.00
		LESS: COPAYMENT	1,164.00
		REIMBURSEMENT	177,273.69
		ALL OTHER	161,263.04
		FEE SCHEDULE-LAB	13,965.12
		INJECTABLE DRUGS	2,045.53

TOTAL NUMBER OF CLAIMS 702

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,227.64	385.67
MED/SURG SUPPLY	6,163.92	274.56
LABORATORY-GENERAL	0.00	136.16
RADIOLOGY-DIAGNOSTIC	28,122.78	0.00
CT SCAN	41,515.91	15,035.08
PHYSICAL THERAPY	0.00	354.64
EKG/ECG	5,746.54	179.23
IV THERAPY	14,923.40	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,315.08	639.75
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	67,690.98	725.73
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,872.93	473.36
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,848.07	397.59
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,461.05	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/OBSERV. RM	3,199.92	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	581.52	28.41
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	113,829.40	39,477.30
MRI SERVICES	11,413.68	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,402.07	3,978.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,629.83

TOTAL ANCILLARY	321,314.89	63,715.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	321,314.89	63,715.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011027056147	11/24/10 - 11/24/10	01/31/11	0.00	1,629.83	0.00	0.00	0.00
TOTAL				0.00	1,629.83	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,296.03	ADJUSTMENTS	0.00
COVERED CHARGES	19,494.80	CONTRACTUAL ALLOW	15,994.80
NON-COVERD CHARGES	801.23	TOTAL MEDICAID LIAB	3,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	3,389.00

TOTAL NUMBER OF CLAIMS 70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.46	272.28
MED/SURG SUPPLY	71.23	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	781.14	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	100.62	0.00
IV THERAPY	205.85	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	101.16	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,286.98	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,081.75	394.78
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	776.61	134.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,494.80	801.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,494.80	801.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,284,280.96	ADJUSTMENTS	0.00
COVERED CHARGES	1,268,655.96	CONTRACTUAL ALLOW	793,621.86
NON-COVERD CHARGES	15,625.00	TOTAL MEDICAID LIAB	475,034.10
		LESS: COB	2,388.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	472,646.08

TOTAL NUMBER OF ADMISSIONS 86

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	328	0	147,600.00	13,925.00
ROUTINE NURSERY	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	328	0	147,600.00	13,925.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	45	0	45,000.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	45	0	45,000.00	0.00
TOTAL ACCOMODATIONS	373	0	192,600.00	13,925.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,425.30	0.00
MED/SURG SUPPLY	203,278.00	0.00
LABORATORY-GENERAL	170,114.00	0.00
RADIOLOGY-DIAGNOSTIC	31,599.00	0.00
CT SCAN	69,511.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,208.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,289.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	123,077.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	16,530.00	0.00
EMERGENCY ROOM	36,954.00	0.00
RECOVERY ROOM	2,970.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,952.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,750.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,983.96	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,200.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	462.00	1,700.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,610.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,600.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	183,542.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,076,055.96	1,700.00
TOTAL ACCOMODATIONS	192,600.00	13,925.00
TOTAL CHARGES	1,268,655.96	15,625.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,305,539.20	ADJUSTMENTS	17,767.64
COVERED CHARGES	1,176,291.80	CONTRACTUAL ALLOW	817,920.13
NON-COVERD CHARGES	129,247.40	TOTAL MEDICAID LIAB	358,371.67
		LESS: COB	5,169.32
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	352,734.35
		ALL OTHER	313,468.13
		FEE SCHEDULE-LAB	37,817.97
		INJECTABLE DRUGS	1,448.25

TOTAL NUMBER OF CLAIMS 1,462

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,272.30	761.00
MED/SURG SUPPLY	80,485.00	4,170.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,291.00	5,150.00
CT SCAN	251,754.00	12,809.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	15,344.00	112.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,612.00	7,678.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,415.00	87.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,533.00	1,320.00
EMERGENCY ROOM	194,926.00	1,682.00
RECOVERY ROOM	1,802.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	23,024.00	250.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	625.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,200.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,059.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	38,412.00	297.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,202.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	340.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	301,223.00	72,815.80
MRI SERVICES	23,800.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,312.50	21,775.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,176,291.80	129,247.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,176,291.80	129,247.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,581.40	ADJUSTMENTS	0.00
COVERED CHARGES	16,487.60	CONTRACTUAL ALLOW	3,270.22
NON-COVERD CHARGES	6,093.80	TOTAL MEDICAID LIAB	13,217.38
		LESS: COB	13,208.38
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	911.60	0.00
MED/SURG SUPPLY	1,590.00	40.00
LABORATORY-GENERAL	0.00	20.00
RADIOLOGY-DIAGNOSTIC	2,671.00	0.00
CT SCAN	2,806.00	1,403.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	112.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	3,165.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,431.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,510.00	0.00
RECOVERY ROOM	495.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	902.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	154.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,837.00	512.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	68.00	953.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,487.60	6,093.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,487.60	6,093.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	109,034.00	ADJUSTMENTS	38.00
COVERED CHARGES	105,620.00	CONTRACTUAL ALLOW	98,670.00
NON-COVERD CHARGES	3,414.00	TOTAL MEDICAID LIAB	6,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	279.01
		REIMBURSEMENT	6,670.99

TOTAL NUMBER OF CLAIMS 139

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,462.00	0.00	OTHER LAB	880.00	0.00
MED/SURG SUPPLY	5,085.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,785.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,782.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,022.00	1,346.00
EKG/ECG	784.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,288.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,383.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,129.00	2,068.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	820.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,200.00	0.00			

TOTAL ANCILLARY	105,620.00	3,414.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,620.00	3,414.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,848.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,652.00	CONTRACTUAL ALLOW	3,483.78
NON-COVERD CHARGES	196.00	TOTAL MEDICAID LIAB	168.22
		LESS: COB	162.22
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	215.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,403.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	684.00	196.00
EKG/ECG	224.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,013.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,652.00	196.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,652.00	196.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSPITAL
PO BOX 1690
HAZLEHURST,GA 31539-1690

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	496,238.10	ADJUSTMENTS	15,725.34
COVERED CHARGES	492,433.10	CONTRACTUAL ALLOW	40,102.93
NON-COVERD CHARGES	3,805.00	TOTAL MEDICAID LIAB	452,330.17
		LESS: COB	4,491.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	447,838.86

TOTAL NUMBER OF ADMISSIONS 79

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	270	0	108,300.00	0.00
ROUTINE NURSERY	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	270	0	108,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	270	0	108,300.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,127.00	0.00
MED/SURG SUPPLY	54,490.00	0.00
LABORATORY-GENERAL	93,328.00	0.00
RADIOLOGY-DIAGNOSTIC	9,237.00	0.00
CT SCAN	19,330.00	0.00
PHYSICAL THERAPY	1,253.00	0.00
EKG/ECG	11,460.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	704.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30,114.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,746.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	114.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	726.00	0.00
BLOOD	3,157.00	0.00
BLOOD STORAGE & PRO.	3,529.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,150.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	507.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	479.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	210.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,472.00	3,805.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	384,133.10	3,805.00
TOTAL ACCOMODATIONS	108,300.00	0.00
TOTAL CHARGES	492,433.10	3,805.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	929,782.10	ADJUSTMENTS	5,791.50
COVERED CHARGES	828,082.10	CONTRACTUAL ALLOW	527,070.30
NON-COVERD CHARGES	101,700.00	TOTAL MEDICAID LIAB	301,011.80
		LESS: COB	707.18
		LESS: COPAYMENT	2,160.00
		REIMBURSEMENT	298,144.62
		ALL OTHER	247,525.16
		FEE SCHEDULE-LAB	48,308.17
		INJECTABLE DRUGS	2,311.29

TOTAL NUMBER OF CLAIMS 1,831

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,852.20	451.00
MED/SURG SUPPLY	56,589.00	0.00
LABORATORY-GENERAL	0.00	35.00
RADIOLOGY-DIAGNOSTIC	44,849.00	2,581.00
CT SCAN	67,636.00	14,712.00
PHYSICAL THERAPY	5,346.00	329.00
EKG/ECG	23,350.00	1,592.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,864.00	2,002.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,252.00	1,210.00
ANESTHESIA	2,948.00	506.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	214,017.00	10,634.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,976.00	832.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	41,261.00	83.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	33,472.00	164.00
BLOOD	1,505.00	0.00
BLOOD STORAGE & PRO.	0.00	2,483.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,600.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,222.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,523.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	217,209.00	53,587.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,610.80	10,499.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	828,082.10	101,700.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	828,082.10	101,700.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	70,298.50	ADJUSTMENTS	0.00
COVERED CHARGES	66,924.75	CONTRACTUAL ALLOW	58,477.81
NON-COVERD CHARGES	3,373.75	TOTAL MEDICAID LIAB	8,446.94
		LESS: COB	0.00
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	8,158.94

TOTAL NUMBER OF CLAIMS 151

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,900.00	27.00
MED/SURG SUPPLY	3,367.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,125.00	147.00
CT SCAN	3,672.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,524.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	885.00	187.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,053.00	612.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,432.00	2,027.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	966.75	373.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	66,924.75	3,373.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,924.75	3,373.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	324.00	ADJUSTMENTS	0.00
COVERED CHARGES	324.00	CONTRACTUAL ALLOW	189.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	134.20
		LESS: COB	134.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	128.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	324.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	324.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE ST # 352
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	90,911.45	ADJUSTMENTS	0.00
COVERED CHARGES	88,959.45	CONTRACTUAL ALLOW	49,693.62
NON-COVERD CHARGES	1,952.00	TOTAL MEDICAID LIAB	39,265.83
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,265.83

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	29	0	13,050.00	0.00
ROUTINE NURSERY	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	29	0	13,050.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	29	0	13,050.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,995.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,987.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,479.60	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,614.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,692.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	264.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,443.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	231.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,414.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,952.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	75,909.45	1,952.00
TOTAL ACCOMODATIONS	13,050.00	0.00
TOTAL CHARGES	88,959.45	1,952.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	114,818.62	ADJUSTMENTS	527.69
COVERED CHARGES	100,085.12	CONTRACTUAL ALLOW	63,028.25
NON-COVERD CHARGES	14,733.50	TOTAL MEDICAID LIAB	37,056.87
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	36,801.87
		ALL OTHER	31,231.66
		FEE SCHEDULE-LAB	5,570.21
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 216

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,036.50	0.00
MED/SURG SUPPLY	7,263.50	0.00
LABORATORY-GENERAL	0.00	226.00
RADIOLOGY-DIAGNOSTIC	7,696.97	0.00
CT SCAN	19,951.70	5,082.35
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,144.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,500.00	1,250.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,002.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,472.00	0.00
RECOVERY ROOM	750.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,826.05	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,526.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	326.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,791.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,799.40	8,175.15
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	100,085.12	14,733.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	100,085.12	14,733.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	525.00	ADJUSTMENTS	0.00
COVERED CHARGES	513.00	CONTRACTUAL ALLOW	269.25
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	243.75
		LESS: COB	243.75
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	319.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87.00	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	92.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	513.00	12.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	513.00	12.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,033.50	ADJUSTMENTS	50.00
COVERED CHARGES	7,947.50	CONTRACTUAL ALLOW	5,797.50
NON-COVERD CHARGES	86.00	TOTAL MEDICAID LIAB	2,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	2,036.00

TOTAL NUMBER OF CLAIMS 43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,232.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	349.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	446.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	715.00	86.00
EKG/ECG	88.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,930.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	187.00	0.00			

TOTAL ANCILLARY	7,947.50	86.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,947.50	86.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,416.10	ADJUSTMENTS	0.00
COVERED CHARGES	80,073.05	CONTRACTUAL ALLOW	62,608.97
NON-COVERD CHARGES	343.05	TOTAL MEDICAID LIAB	17,464.08
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	17,452.08

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	974.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,495.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,016.75	343.05
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,587.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	80,073.05	343.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,073.05	343.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 10/03/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,887.80	ADJUSTMENTS	8,064.15
COVERED CHARGES	87,422.80	CONTRACTUAL ALLOW	28,877.84
NON-COVERD CHARGES	10,465.00	TOTAL MEDICAID LIAB	58,544.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	58,544.96

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	37	0	16,650.00	10,465.00
ROUTINE NURSERY	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	37	0	16,650.00	10,465.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	37	0	16,650.00	10,465.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,741.40	0.00	OTHER LAB	612.70	0.00
MED/SURG SUPPLY	5,100.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,903.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,314.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,025.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,004.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,617.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,426.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	712.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,680.35	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	707.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	488.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	70,772.80	0.00
TOTAL ACCOMODATIONS	16,650.00	10,465.00
TOTAL CHARGES	87,422.80	10,465.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	558,530.68	ADJUSTMENTS	574.00
COVERED CHARGES	413,276.78	CONTRACTUAL ALLOW	277,720.91
NON-COVERD CHARGES	145,253.90	TOTAL MEDICAID LIAB	135,555.87
		LESS: COB	0.00
		LESS: COPAYMENT	321.00
		REIMBURSEMENT	135,234.87
		ALL OTHER	120,586.83
		FEE SCHEDULE-LAB	14,648.04
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 468

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,882.25	1,415.20
MED/SURG SUPPLY	16,541.70	697.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,031.57	557.70
CT SCAN	15,772.50	16,942.05
PHYSICAL THERAPY	0.00	873.00
EKG/ECG	5,324.00	88.00
IV THERAPY	0.00	0.00
OPERATING ROOM	54,604.80	70,531.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,027.00	132.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,652.70	128.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,828.20	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/OBSERV. RM	2,354.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	28,528.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	167,728.66	53,889.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	413,276.78	145,253.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	413,276.78	145,253.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	560.50	ADJUSTMENTS	0.00
COVERED CHARGES	544.55	CONTRACTUAL ALLOW	541.55
NON-COVERD CHARGES	15.95	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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	544.55	15.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	544.55	15.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	544.55	15.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/04/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,389.00	ADJUSTMENTS	97.00
COVERED CHARGES	46,912.20	CONTRACTUAL ALLOW	41,212.20
NON-COVERD CHARGES	1,476.80	TOTAL MEDICAID LIAB	5,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	5,466.00

TOTAL NUMBER OF CLAIMS 114

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,730.30	8.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,228.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	999.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,041.20	1,392.15
EKG/ECG	440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	76.65
OPERATING ROOM	6,067.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,339.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	46,912.20	1,476.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,912.20	1,476.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/04/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	237,143.42	ADJUSTMENTS	4,363.02
COVERED CHARGES	194,609.22	CONTRACTUAL ALLOW	146,583.00
NON-COVERD CHARGES	42,534.20	TOTAL MEDICAID LIAB	48,026.22
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	47,993.22

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,259.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,553.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	538.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,524.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,186.65	63.80
EKG/ECG	924.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	182,622.72	42,470.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	194,609.22	42,534.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,609.22	42,534.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
210 E DERENNE AVENUE
SAVANNAH,GA 31405-0000

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/04/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,273,062.78	ADJUSTMENTS	468,723.53
COVERED CHARGES	6,981,970.78	CONTRACTUAL ALLOW	3,870,296.92
NON-COVERD CHARGES	291,092.00	TOTAL MEDICAID LIAB	3,111,673.86
		LESS: COB	45,797.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,065,876.24

TOTAL NUMBER OF ADMISSIONS 322

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,103	2	857,031.00	120,220.00
ROUTINE NURSERY	0	3	0.00	45.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,103	5	857,031.00	120,265.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	519	0	737,301.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	8,569.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	519	11	737,301.00	8,569.00
TOTAL ACCOMODATIONS	1,622	16	1,594,332.00	128,834.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	823,452.00	293.00
MED/SURG SUPPLY	113,896.00	1,252.00
LABORATORY-GENERAL	833,940.78	564.00
RADIOLOGY-DIAGNOSTIC	299,839.00	0.00
CT SCAN	639,946.00	38,435.00
PHYSICAL THERAPY	16,541.00	413.00
EKG/ECG	78,470.00	0.00
IV THERAPY	13,645.00	0.00
OPERATING ROOM	365,644.00	7,726.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	304,391.00	240.00
ANESTHESIA	79,576.00	0.00
GI SERVICES	61,885.00	0.00
EMERGENCY ROOM	602,973.00	5,157.00
RECOVERY ROOM	67,846.00	0.00
LABORATORY PATHOLOGIC	82,936.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,727.00	0.00
SPEECH PATHOLOGY	8,829.00	0.00
RENAL DIALYSIS	1,600.00	85,000.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	100.00	1,450.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	79,492.00	7,017.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	60,729.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	145,176.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	150,037.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,054.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,780.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	72,947.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,332.00	0.00
OTHER THERAPEUTIC SVC	0.00	663.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	132,634.00	9,370.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	1,100.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	331,221.00	743.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,835.00

TOTAL ANCILLARY	5,387,638.78	162,258.00
TOTAL ACCOMODATIONS	1,594,332.00	128,834.00
TOTAL CHARGES	6,981,970.78	291,092.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	2210314000816	07/20/10 - 07/20/10	11/15/10	0.00	2,835.00	0.00	0.00	0.00
TOTAL				0.00	2,835.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,335.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,495.00	CONTRACTUAL ALLOW	9,285.40
NON-COVERD CHARGES	840.00	TOTAL MEDICAID LIAB	10,209.60
		LESS: COB	10,209.60
		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	5	0	3,885.00	840.00
ROUTINE NURSERY	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	3,885.00	840.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	3,885.00	840.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,107.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,802.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,076.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	412.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,423.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,610.00	0.00
TOTAL ACCOMODATIONS	3,885.00	840.00
TOTAL CHARGES	19,495.00	840.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,297,978.92	ADJUSTMENTS	171,465.88
COVERED CHARGES	4,368,116.00	CONTRACTUAL ALLOW	3,482,638.14
NON-COVERD CHARGES	929,862.92	TOTAL MEDICAID LIAB	885,477.86
		LESS: COB	3.99
		LESS: COPAYMENT	2,265.47
		REIMBURSEMENT	883,208.40
		ALL OTHER	793,828.60
		FEE SCHEDULE-LAB	74,588.55
		INJECTABLE DRUGS	14,791.25

TOTAL NUMBER OF CLAIMS 2,093

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188,499.00	2,002.00
MED/SURG SUPPLY	22,306.00	30,369.42
LABORATORY-GENERAL	0.00	273.00
RADIOLOGY-DIAGNOSTIC	362,740.00	9,243.00
CT SCAN	510,645.00	276,045.00
PHYSICAL THERAPY	3,463.00	2,570.00
EKG/ECG	86,110.00	0.00
IV THERAPY	25,445.00	1,391.00
OPERATING ROOM	217,214.00	246,918.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,669.00	9,404.00
ANESTHESIA	110,382.00	0.00
GI SERVICES	65,230.00	16,182.00
EMERGENCY ROOM	1,156,105.00	27,294.00
RECOVERY ROOM	98,765.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,966.00	0.00
SPEECH PATHOLOGY	0.00	170.00
RENAL DIALYSIS	0.00	6,400.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	194.00	50.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	266,501.00	6,343.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	46,100.00	40,844.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	97,560.00	28,880.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30,050.00	12,841.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,762.00	1,430.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	53,305.00	5,932.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8.00	140.00
OTHER THERAPEUTIC SVC	0.00	1,560.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	685,917.00	93,655.50
MRI SERVICES	176,618.00	57,457.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	120,562.00	52,469.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,368,116.00	929,862.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,368,116.00	929,862.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,208.25	ADJUSTMENTS	0.00
COVERED CHARGES	27,950.25	CONTRACTUAL ALLOW	19,570.84
NON-COVERD CHARGES	19,258.00	TOTAL MEDICAID LIAB	8,379.41
		LESS: COB	8,372.85
		LESS: COPAYMENT	6.56
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,529.00	0.00
MED/SURG SUPPLY	25.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,991.00	0.00
CT SCAN	2,274.00	6,708.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	798.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	7,563.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	67.00	134.00
ANESTHESIA	2,018.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,512.00	0.00
RECOVERY ROOM	1,891.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,436.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,132.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,749.25	785.00
MRI SERVICES	0.00	3,971.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,528.00	55.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	27,950.25	19,216.00
TOTAL ACCOMODATIONS	0.00	42.00
TOTAL CHARGES	27,950.25	19,258.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	283,705.00	ADJUSTMENTS	1,397.44
COVERED CHARGES	256,016.00	CONTRACTUAL ALLOW	242,409.87
NON-COVERD CHARGES	27,689.00	TOTAL MEDICAID LIAB	13,606.13
		LESS: COB	0.00
		LESS: COPAYMENT	411.03
		REIMBURSEMENT	13,195.10

TOTAL NUMBER OF CLAIMS 243

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,810.00	0.00
MED/SURG SUPPLY	105.00	333.00
LABORATORY-GENERAL	0.00	102.00
RADIOLOGY-DIAGNOSTIC	25,848.00	375.00
CT SCAN	19,632.00	12,292.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,054.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,890.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	201.00	0.00
ANESTHESIA	1,466.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,333.00	4,295.00
RECOVERY ROOM	1,428.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,050.00	3,354.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	181.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,364.00	960.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	38,827.00	3,949.00
MRI SERVICES	3,070.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,757.00	2,029.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	256,016.00	27,689.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	256,016.00	27,689.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	449.00	ADJUSTMENTS	0.00
COVERED CHARGES	449.00	CONTRACTUAL ALLOW	307.15
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	141.85
		LESS: COB	141.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	138.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	311.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	449.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	449.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,529.75	ADJUSTMENTS	5,738.29
COVERED CHARGES	79,172.75	CONTRACTUAL ALLOW	61,930.88
NON-COVERD CHARGES	357.00	TOTAL MEDICAID LIAB	17,241.87
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	17,208.87

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,145.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	302.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	130.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,342.75	26.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,621.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,935.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134.00	201.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,630.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,760.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	703.00	0.00			

TOTAL ANCILLARY	79,172.75	357.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,172.75	357.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
PO BOX 1190
LAWRENCEVILLE,GA 30046-1190

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,721,250.67	ADJUSTMENTS	43,183.68
COVERED CHARGES	6,688,397.03	CONTRACTUAL ALLOW	4,376,500.95
NON-COVERD CHARGES	32,853.64	TOTAL MEDICAID LIAB	2,311,896.08
		LESS: COB	42,566.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,269,329.90

TOTAL NUMBER OF ADMISSIONS 337

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	468	0	319,644.00	47.00
ROUTINE NURSERY	100	0	42,036.00	188.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	568	0	361,680.00	235.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,474	0	709,964.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,474	0	709,964.00	0.00
TOTAL ACCOMODATIONS	2,042	0	1,071,644.00	235.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,548,454.07	0.00
MED/SURG SUPPLY	360,058.07	0.00
LABORATORY-GENERAL	1,244,214.14	0.00
RADIOLOGY-DIAGNOSTIC	139,145.80	0.00
CT SCAN	156,291.45	28,990.52
PHYSICAL THERAPY	34,808.00	0.00
EKG/ECG	66,136.24	0.00
IV THERAPY	75,681.72	0.00
OPERATING ROOM	294,730.92	0.00
LABOR/DELIVERY ROOM	90,541.20	0.00
RESPIRATORY SERVICES	895,638.12	0.00
ANESTHESIA	31,095.60	0.00
GI SERVICES	20,438.23	0.00
EMERGENCY ROOM	158,506.81	0.00
RECOVERY ROOM	60,427.08	0.00
LABORATORY PATHOLOGIC	14,755.00	0.00
RADIOLOGY THERAPEUTIC	2,463.64	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	871.00	0.00
RENAL DIALYSIS	0.00	1,524.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	267.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,250.12	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	38,815.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,512.36	1,784.00
AUDIOLOGY	2,538.00	0.00
CARDIOLOGY	138,792.44	0.00
AMBULATORY SURGERY	5,324.40	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	89,433.06	269.12

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	79,590.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	29.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	15,824.72	0.00
PROFESSIONAL FEES	0.00	51.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,119.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,616,753.03	32,618.64
TOTAL ACCOMODATIONS	1,071,644.00	235.00
TOTAL CHARGES	6,688,397.03	32,853.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	95,549.32	ADJUSTMENTS	0.00
COVERED CHARGES	95,396.32	CONTRACTUAL ALLOW	19,813.70
NON-COVERD CHARGES	153.00	TOTAL MEDICAID LIAB	75,582.62
		LESS: COB	75,582.62
		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	11	0	7,513.00	0.00
ROUTINE NURSERY	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	11	0	7,513.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	12	0	8,846.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	12	0	8,846.00	0.00
TOTAL ACCOMODATIONS	23	0	16,359.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,012.06	0.00
MED/SURG SUPPLY	2,013.00	0.00
LABORATORY-GENERAL	24,254.52	0.00
RADIOLOGY-DIAGNOSTIC	1,813.72	0.00
CT SCAN	4,166.00	0.00
PHYSICAL THERAPY	253.00	0.00
EKG/ECG	807.36	0.00
IV THERAPY	1,388.74	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,064.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,458.56	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 SERVICE	575.36	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	392.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,989.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,589.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,260.84	0.00
PROFESSIONAL FEES	0.00	153.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	79,037.32	153.00
TOTAL ACCOMODATIONS	16,359.00	0.00
TOTAL CHARGES	95,396.32	153.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,543,386.93	ADJUSTMENTS	252,074.90
COVERED CHARGES	10,277,825.32	CONTRACTUAL ALLOW	8,260,118.96
NON-COVERD CHARGES	1,265,561.61	TOTAL MEDICAID LIAB	2,017,706.36
		LESS: COB	8,307.54
		LESS: COPAYMENT	10,117.26
		REIMBURSEMENT	1,999,281.56
		ALL OTHER	1,532,551.19
		FEE SCHEDULE-LAB	233,938.78
		INJECTABLE DRUGS	232,791.59

TOTAL NUMBER OF CLAIMS 6,275

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	940,202.28	42,136.44
MED/SURG SUPPLY	464,738.53	8,368.00
LABORATORY-GENERAL	0.00	802.44
RADIOLOGY-DIAGNOSTIC	459,029.80	12,249.72
CT SCAN	541,923.90	46,587.95
PHYSICAL THERAPY	53,539.77	16,949.00
EKG/ECG	138,865.92	1,480.16
IV THERAPY	379,335.04	8,102.40
OPERATING ROOM	482,085.99	73,682.80
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	84,957.96	3,557.40
ANESTHESIA	72,621.04	529.60
GI SERVICES	73,569.04	3,040.72
EMERGENCY ROOM	971,285.78	33,847.68
RECOVERY ROOM	150,572.72	428.76
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	783,026.37	4,936.04
OCCUPATIONAL THERAPY	1,165.00	0.00
SPEECH PATHOLOGY	228.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	139,795.00	16,614.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	156,570.12	10,780.44
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,604.00	8,782.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	185,405.12	112,205.04
AUDIOLOGY	0.00	0.00
CARDIOLOGY	169,564.56	18,331.20
AMBULATORY SURGERY	57,124.98	18,556.02
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,224.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	129,641.09	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	402,838.19	66,809.60
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,875,923.88	455,110.70
MRI SERVICES	70,299.48	10,550.20
PROFESSIONAL FEES	0.00	153.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,476,687.76	290,970.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,277,825.32	1,265,561.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,277,825.32	1,265,561.61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	237,190.81	ADJUSTMENTS	0.00
COVERED CHARGES	212,497.44	CONTRACTUAL ALLOW	149,214.08
NON-COVERD CHARGES	24,693.37	TOTAL MEDICAID LIAB	63,283.36
		LESS: COB	63,126.23
		LESS: COPAYMENT	157.13
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	129

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,169.67	293.30	OTHER LAB	9,813.72	1,147.44
MED/SURG SUPPLY	11,980.00	51.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	119.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,477.64	630.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,550.06	1,877.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,837.75	11,547.32
EKG/ECG	4,238.64	269.12	MRI SERVICES	0.00	0.00
IV THERAPY	4,523.44	336.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,344.80	2,740.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,110.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,664.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,175.41	1,179.04	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,258.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,937.74	2,137.00
RADIOLOGY THERAPEUTIC	7,459.04	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	200.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,178.24	1,150.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,176.00	1,215.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,967.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,436.01	0.00			

TOTAL ANCILLARY	212,497.44	24,693.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	212,497.44	24,693.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	398,199.33	ADJUSTMENTS	1,718.04
COVERED CHARGES	344,867.17	CONTRACTUAL ALLOW	318,966.98
NON-COVERD CHARGES	53,332.16	TOTAL MEDICAID LIAB	25,900.19
		LESS: COB	0.00
		LESS: COPAYMENT	942.06
		REIMBURSEMENT	24,958.13

TOTAL NUMBER OF CLAIMS 463

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,091.21	10.10	OTHER LAB	21,573.44	1,781.52
MED/SURG SUPPLY	4,264.06	512.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	67.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,158.44	183.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,764.94	1,465.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	267.00	84.00	FEE SCHEDULE LAB	109,888.14	38,906.64
EKG/ECG	3,767.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,339.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,144.50	2,920.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,680.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,234.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,815.60	1,161.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,077.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,436.60	5,000.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	268.00	89.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,876.80	1,150.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,219.00	0.00			

TOTAL ANCILLARY	344,867.17	53,332.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	344,867.17	53,332.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,534.94	ADJUSTMENTS	0.00
COVERED CHARGES	5,359.08	CONTRACTUAL ALLOW	3,055.93
NON-COVERD CHARGES	1,175.86	TOTAL MEDICAID LIAB	2,303.15
		LESS: COB	2,291.15
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.01	0.00	OTHER LAB	178.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	366.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,266.56	371.20
EKG/ECG	269.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,233.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	303.55	229.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	575.36	575.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,359.08	1,175.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,359.08	1,175.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	757,584.56	ADJUSTMENTS	30,025.45
COVERED CHARGES	751,267.18	CONTRACTUAL ALLOW	574,609.95
NON-COVERD CHARGES	6,317.38	TOTAL MEDICAID LIAB	176,657.23
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	176,471.23

TOTAL NUMBER OF CLAIMS 35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,472.84	0.00
MED/SURG SUPPLY	15,601.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,462.20	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	807.36	0.00
IV THERAPY	840.00	0.00
OPERATING ROOM	10,757.01	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	970.00	0.00
ANESTHESIA	1,340.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	581.23	0.00
RECOVERY ROOM	599.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	82,177.35	1,518.44
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	392.00	235.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,989.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	648.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,219.04	380.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,118.40	2,507.44
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	539,292.35	1,676.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	751,267.18	6,317.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	751,267.18	6,317.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,307,920.78	ADJUSTMENTS	375,710.89
COVERED CHARGES	9,235,731.60	CONTRACTUAL ALLOW	6,017,779.72
NON-COVERD CHARGES	72,189.18	TOTAL MEDICAID LIAB	3,217,951.88
		LESS: COB	26,463.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,191,488.29

TOTAL NUMBER OF ADMISSIONS 694

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,107	25	888,340.00	31,660.00
ROUTINE NURSERY	397	0	313,825.00	13,053.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	1,504	28	1,202,165.00	44,713.00
SPECIAL CARE SERVICES				
CCU	153	0	207,500.00	0.00
ICU	172	0	344,000.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	325	0	551,500.00	0.00
TOTAL ACCOMODATIONS	1,829	28	1,753,665.00	44,713.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	530,143.12	0.00
MED/SURG SUPPLY	678,809.01	0.00
LABORATORY-GENERAL	954,471.23	0.00
RADIOLOGY-DIAGNOSTIC	167,676.39	0.00
CT SCAN	445,486.49	0.00
PHYSICAL THERAPY	33,422.25	0.00
EKG/ECG	139,925.17	0.00
IV THERAPY	5,519.25	0.00
OPERATING ROOM	1,135,467.71	0.00
LABOR/DELIVERY ROOM	625,483.50	0.00
RESPIRATORY SERVICES	214,470.82	0.00
ANESTHESIA	193,609.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	529,101.50	0.00
RECOVERY ROOM	183,554.75	0.00
LABORATORY PATHOLOGIC	30,232.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,345.25	0.00
SPEECH PATHOLOGY	3,949.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65.00	1,132.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	69,965.73	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	141,837.14	11,016.45
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	54,091.52	7,045.46
AUDIOLOGY	86,400.00	0.00
CARDIOLOGY	329,150.51	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,751.41	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	30,769.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	136.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	79,292.11	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	810,076.79	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	8,145.52

TOTAL ANCILLARY	7,482,066.60	27,476.18
TOTAL ACCOMODATIONS	1,753,665.00	44,713.00
TOTAL CHARGES	9,235,731.60	72,189.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	4410259116519	08/08/10 - 08/08/10	09/27/10	0.00	2,036.38	0.00	0.00	0.00
615	2010328065427	07/21/10 - 07/24/10	11/29/10	0.00	2,036.38	0.00	0.00	0.00
615	2211110011366	02/05/11 - 02/08/11	04/25/11	0.00	2,036.38	0.00	0.00	0.00
615	2011133000189	04/13/11 - 04/15/11	05/16/11	0.00	2,036.38	0.00	0.00	0.00
TOTAL				0.00	8,145.52	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,693.77	ADJUSTMENTS	0.00
COVERED CHARGES	18,071.77	CONTRACTUAL ALLOW	4,570.82
NON-COVERD CHARGES	622.00	TOTAL MEDICAID LIAB	13,500.95
		LESS: COB	13,500.95
		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	4	0	2,960.00	0.00
ROUTINE NURSERY	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	2,960.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	2,960.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	733.84	0.00
MED/SURG SUPPLY	501.52	0.00
LABORATORY-GENERAL	757.17	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	9,862.50	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	1,472.50	0.00
LABORATORY PATHOLOGIC	576.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	320.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	622.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	888.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,111.77	622.00
TOTAL ACCOMODATIONS	2,960.00	0.00
TOTAL CHARGES	18,071.77	622.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,969,957.85	ADJUSTMENTS	319,457.41
COVERED CHARGES	8,800,151.30	CONTRACTUAL ALLOW	6,978,570.15
NON-COVERD CHARGES	1,169,806.55	TOTAL MEDICAID LIAB	1,821,581.15
		LESS: COB	4,848.58
		LESS: COPAYMENT	7,605.32
		REIMBURSEMENT	1,809,127.25
		ALL OTHER	1,608,965.16
		FEE SCHEDULE-LAB	184,466.84
		INJECTABLE DRUGS	15,695.25

TOTAL NUMBER OF CLAIMS 5,521

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,489.80	1,428.80
MED/SURG SUPPLY	257,709.01	43,951.97
LABORATORY-GENERAL	0.00	446.75
RADIOLOGY-DIAGNOSTIC	571,809.61	12,762.98
CT SCAN	1,167,393.80	156,144.16
PHYSICAL THERAPY	51,974.50	6,087.50
EKG/ECG	84,798.18	275.00
IV THERAPY	60,406.75	0.00
OPERATING ROOM	1,106,622.71	294,041.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	76,949.93	7,283.50
ANESTHESIA	221,763.35	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,740,073.17	26,477.50
RECOVERY ROOM	146,124.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,728.00	1,318.75
SPEECH PATHOLOGY	4,019.50	1,199.25
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	30,922.56	65.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	96,487.50	0.00
OTHER IMAGING SERVICE	288,803.57	13,033.92
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,578.87	617.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	81,088.38	41,440.77
AUDIOLOGY	0.00	0.00
CARDIOLOGY	160,737.78	111,596.50
AMBULATORY SURGERY	7,047.84	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	275,572.53	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	57,010.68	17,359.37

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	60,103.00	6,901.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,373,368.49	285,075.42
MRI SERVICES	565,352.42	9,175.51
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	201,214.62	121,685.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	9,765.26

TOTAL ANCILLARY	8,800,151.30	1,168,133.55
TOTAL ACCOMODATIONS	0.00	1,673.00
TOTAL CHARGES	8,800,151.30	1,169,806.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
60	4010263062209	08/10/10 - 08/10/10	10/04/10	0.00	5,692.50	0.00	0.00	0.00
615	2010363088445	08/20/10 - 08/20/10	01/03/11	0.00	2,036.38	0.00	0.00	0.00
615	2011061080057	02/21/11 - 02/21/11	03/07/11	0.00	2,036.38	0.00	0.00	0.00
TOTAL				0.00	9,765.26	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,208.17	ADJUSTMENTS	0.00
COVERED CHARGES	46,046.45	CONTRACTUAL ALLOW	13,527.88
NON-COVERD CHARGES	14,161.72	TOTAL MEDICAID LIAB	32,518.57
		LESS: COB	32,506.57
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	631.59	0.00
MED/SURG SUPPLY	1,155.24	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,951.95	0.00
CT SCAN	2,441.00	4,009.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	210.00	0.00
IV THERAPY	112.75	0.00
OPERATING ROOM	0.00	3,344.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	493.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,854.25	343.50
RECOVERY ROOM	431.25	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	374.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,047.00	2,978.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,200.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	163.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,211.50	552.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,017.29	537.33
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,952.38	1,197.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	46,046.45	14,161.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,046.45	14,161.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	735,620.50	ADJUSTMENTS	6,310.98
COVERED CHARGES	708,537.11	CONTRACTUAL ALLOW	667,126.65
NON-COVERD CHARGES	27,083.39	TOTAL MEDICAID LIAB	41,410.46
		LESS: COB	0.00
		LESS: COPAYMENT	1,428.07
		REIMBURSEMENT	39,982.39

TOTAL NUMBER OF CLAIMS 740

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,009.09	35.00
MED/SURG SUPPLY	5,763.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,571.90	0.00
CT SCAN	51,601.94	4,439.98
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,138.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,050.00	65.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	443,616.75	3,001.50
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 SERVICE	10,797.75	900.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	92.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	534.45	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	470.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	107,993.65	14,189.46
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,897.48	4,452.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	708,537.11	27,083.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	708,537.11	27,083.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,288.74	ADJUSTMENTS	0.00
COVERED CHARGES	14,986.24	CONTRACTUAL ALLOW	10,795.50
NON-COVERD CHARGES	302.50	TOTAL MEDICAID LIAB	4,190.74
		LESS: COB	4,172.74
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37.50	0.00
MED/SURG SUPPLY	126.52	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	855.50	0.00
CT SCAN	2,004.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	210.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	60.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,019.25	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,470.85	302.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	202.12	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,986.24	302.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,986.24	302.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	509,215.47	ADJUSTMENTS	25,481.35
COVERED CHARGES	484,244.55	CONTRACTUAL ALLOW	397,115.58
NON-COVERD CHARGES	24,970.92	TOTAL MEDICAID LIAB	87,128.97
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	86,864.97

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,922.54	0.00
MED/SURG SUPPLY	58,879.62	5,480.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,829.75	1,720.50
CT SCAN	9,443.49	6,444.48
PHYSICAL THERAPY	0.00	71.75
EKG/ECG	0.00	0.00
IV THERAPY	2,706.00	0.00
OPERATING ROOM	154,403.50	280.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	149,090.86	853.56
ANESTHESIA	32,337.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,329.00	578.00
RECOVERY ROOM	12,624.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37,997.62	1,804.95
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,771.62	1,300.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	231.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,328.28	478.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,348.49	5,958.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	484,244.55	24,970.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	484,244.55	24,970.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,948.03	ADJUSTMENTS	0.00
COVERED CHARGES	34,733.53	CONTRACTUAL ALLOW	34,733.53
NON-COVERD CHARGES	8,214.50	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,367.43	8,019.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	630.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,973.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,211.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,860.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	426.68	195.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	34,733.53	8,214.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,733.53	8,214.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,490,228.50	ADJUSTMENTS	1,253,335.52
COVERED CHARGES	11,089,537.50	CONTRACTUAL ALLOW	7,538,925.97
NON-COVERD CHARGES	400,691.00	TOTAL MEDICAID LIAB	3,550,611.53
		LESS: COB	18,080.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,532,531.29

TOTAL NUMBER OF ADMISSIONS 734

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,523	8	1,152,769.00	252,437.00
ROUTINE NURSERY	639	0	547,408.00	35,110.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,162	8	1,700,177.00	287,547.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	126	0	367,371.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	126	0	367,371.00	0.00
TOTAL ACCOMODATIONS	2,288	8	2,067,548.00	287,547.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	395,948.50	2,040.50
MED/SURG SUPPLY	721,979.00	5,794.00
LABORATORY-GENERAL	1,538,456.00	3,498.00
RADIOLOGY-DIAGNOSTIC	132,776.00	0.00
CT SCAN	280,532.00	0.00
PHYSICAL THERAPY	90,853.00	0.00
EKG/ECG	48,462.00	0.00
IV THERAPY	4,985.00	0.00
OPERATING ROOM	645,573.00	19,388.00
LABOR/DELIVERY ROOM	788,989.00	0.00
RESPIRATORY SERVICES	489,599.00	976.00
ANESTHESIA	85,985.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	333,129.00	14,071.00
RECOVERY ROOM	81,518.00	0.00
LABORATORY PATHOLOGIC	37,878.00	0.00
RADIOLOGY THERAPEUTIC	19,018.00	0.00
OCCUPATIONAL THERAPY	28,179.00	0.00
SPEECH PATHOLOGY	17,508.00	0.00
RENAL DIALYSIS	124,304.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	29.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	125,224.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	83,239.00	11,424.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	30,410.00	6,263.00
AUDIOLOGY	43,928.00	0.00
CARDIOLOGY	305,121.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,300.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,058.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	28,031.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	248.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,748.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	147,414.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	83.00
DRUG-SPECIFIC/HOME IV	0.00	38,493.00
INJECTABLE DRUGS	2,387,316.00	4,365.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,021,989.50	113,144.00
TOTAL ACCOMODATIONS	2,067,548.00	287,547.00
TOTAL CHARGES	11,089,537.50	400,691.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	169,311.00	ADJUSTMENTS	0.00
COVERED CHARGES	164,329.00	CONTRACTUAL ALLOW	102,553.18
NON-COVERD CHARGES	4,982.00	TOTAL MEDICAID LIAB	61,775.82
		LESS: COB	61,775.82
		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	19	0	14,970.00	2,911.00
ROUTINE NURSERY	14	0	36,883.00	1,610.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	51,853.00	4,521.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	5,968.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	5,968.00	0.00
TOTAL ACCOMODATIONS	35	0	57,821.00	4,521.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,569.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,951.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,889.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,271.00	0.00	OTHER THERAPEUTIC SVC	0.00	378.00
CT SCAN	2,522.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	596.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	246.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,424.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,524.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,074.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,212.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,580.00	0.00	SPECIAL SERVICES	0.00	83.00
RECOVERY ROOM	696.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	386.00	0.00	INJECTABLE DRUGS	33,375.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	453.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	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	306.00	0.00			
CARDIOLOGY	1,776.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	106,508.00	461.00
TOTAL ACCOMODATIONS	57,821.00	4,521.00
TOTAL CHARGES	164,329.00	4,982.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,120,599.88	ADJUSTMENTS	259,066.76
COVERED CHARGES	6,241,571.68	CONTRACTUAL ALLOW	5,066,599.17
NON-COVERD CHARGES	879,028.20	TOTAL MEDICAID LIAB	1,174,972.51
		LESS: COB	9,276.35
		LESS: COPAYMENT	1,934.58
		REIMBURSEMENT	1,163,761.58
		ALL OTHER	1,058,034.16
		FEE SCHEDULE-LAB	64,974.90
		INJECTABLE DRUGS	40,752.52

TOTAL NUMBER OF CLAIMS 2,294

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,897.50	1,375.00
MED/SURG SUPPLY	272,814.00	20,042.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	254,389.00	7,179.00
CT SCAN	600,795.00	67,861.00
PHYSICAL THERAPY	13,309.00	9,663.00
EKG/ECG	65,928.00	492.00
IV THERAPY	113,789.00	26,311.00
OPERATING ROOM	385,227.00	36,663.00
LABOR/DELIVERY ROOM	73,070.00	0.00
RESPIRATORY SERVICES	45,102.00	451.00
ANESTHESIA	106,924.00	2,380.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,591,719.00	39,190.00
RECOVERY ROOM	118,291.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	188,068.00	34,891.00
OCCUPATIONAL THERAPY	1,911.00	2,915.00
SPEECH PATHOLOGY	1,138.00	1,674.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	406.00	464.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	17,425.00	0.00
OTHER IMAGING SERVICE	308,154.00	28,072.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,891.00	12,852.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	68,615.00	11,026.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	81,036.00	29,578.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	108,015.00	1,774.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	70,390.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	929.00	212.00
OTHER THERAPEUTIC SVC	0.00	11,120.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	997,265.18	205,256.20
MRI SERVICES	103,580.00	9,786.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	468,494.00	317,801.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,241,571.68	879,028.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,241,571.68	879,028.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	132,934.50	ADJUSTMENTS	0.00
COVERED CHARGES	111,932.00	CONTRACTUAL ALLOW	51,633.05
NON-COVERD CHARGES	21,002.50	TOTAL MEDICAID LIAB	60,298.95
		LESS: COB	60,288.79
		LESS: COPAYMENT	10.16
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,138.50	0.00
MED/SURG SUPPLY	4,197.00	335.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,715.00	0.00
CT SCAN	3,948.00	6,823.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	246.00	0.00
IV THERAPY	1,075.00	0.00
OPERATING ROOM	7,655.00	2,431.00
LABOR/DELIVERY ROOM	11,664.00	0.00
RESPIRATORY SERVICES	141.00	0.00
ANESTHESIA	2,384.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	33,598.00	390.00
RECOVERY ROOM	4,207.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,492.00	4,683.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,145.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	330.00	0.00
OTHER THERAPEUTIC SVC	0.00	139.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21,872.00	1,365.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,124.50	4,836.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	111,932.00	21,002.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	111,932.00	21,002.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	431,642.00	ADJUSTMENTS	1,606.19
COVERED CHARGES	404,359.50	CONTRACTUAL ALLOW	380,361.25
NON-COVERD CHARGES	27,282.50	TOTAL MEDICAID LIAB	23,998.25
		LESS: COB	0.00
		LESS: COPAYMENT	765.03
		REIMBURSEMENT	23,233.22

TOTAL NUMBER OF CLAIMS 429

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,304.50	46.50	OTHER LAB	2,250.00	0.00
MED/SURG SUPPLY	3,216.00	224.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,686.00	440.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,471.00	4,849.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,681.00	9,808.00
EKG/ECG	3,444.00	0.00	MRI SERVICES	6,524.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,189.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	757.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,551.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	822.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	247,763.00	2,426.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,067.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,099.00	7,683.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	17,535.00	1,806.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	404,359.50	27,282.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	404,359.50	27,282.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,920.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,582.00	CONTRACTUAL ALLOW	3,561.42
NON-COVERD CHARGES	338.00	TOTAL MEDICAID LIAB	3,020.58
		LESS: COB	3,014.58
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,131.00	338.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,088.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,338.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,582.00	338.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,582.00	338.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,429,538.50	ADJUSTMENTS	49,977.97
COVERED CHARGES	1,301,281.00	CONTRACTUAL ALLOW	1,096,853.69
NON-COVERD CHARGES	128,257.50	TOTAL MEDICAID LIAB	204,427.31
		LESS: COB	8,672.33
		LESS: COPAYMENT	543.34
		REIMBURSEMENT	195,211.64

TOTAL NUMBER OF CLAIMS 41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,216.00	271.00
MED/SURG SUPPLY	90,548.00	1,378.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,516.00	301.00
CT SCAN	38,214.00	1,974.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,952.00	0.00
IV THERAPY	43,554.00	9,963.00
OPERATING ROOM	113,999.00	4.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,881.00	0.00
ANESTHESIA	23,608.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,900.00	0.00
RECOVERY ROOM	14,092.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	292,265.00	10,832.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,231.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,740.00	954.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	47,155.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,657.00	172.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	928.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,482.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,509.00	4,933.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	513,316.00	93,993.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,301,281.00	128,257.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,301,281.00	128,257.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOPSITAL CHEROKEE
PO BOX 906
CANTON,GA 30169-0906

PROVIDER NUMBER
000001108A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,731,907.36	ADJUSTMENTS	10,305,088.44
COVERED CHARGES	84,289,773.11	CONTRACTUAL ALLOW	58,644,169.93
NON-COVERD CHARGES	2,442,134.25	TOTAL MEDICAID LIAB	25,645,603.18
		LESS: COB	242,049.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	25,403,554.17

TOTAL NUMBER OF ADMISSIONS 3,095

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,898	11	5,435,351.61	635,472.69
ROUTINE NURSERY	2,021	0	812,204.00	65,586.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	14	0.00	8,222.00
TOTAL ROUTINE	7,919	25	6,247,555.61	709,280.69
SPECIAL CARE SERVICES				
CCU	3,661	0	5,224,166.91	85,081.00
ICU	2,151	0	4,595,950.00	2,321.00
NICU	1,334	0	3,193,220.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	242	0.00	323,348.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,146	242	13,013,336.91	410,750.00
TOTAL ACCOMODATIONS	15,065	267	19,260,892.52	1,120,030.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,994,496.36	409,863.13
MED/SURG SUPPLY	6,444,590.10	109,736.68
LABORATORY-GENERAL	10,140,963.25	96,576.00
RADIOLOGY-DIAGNOSTIC	1,924,314.50	9,941.00
CT SCAN	4,200,350.00	36,230.25
PHYSICAL THERAPY	356,255.00	21,772.00
EKG/ECG	330,433.00	1,786.00
IV THERAPY	102,732.00	29,319.00
OPERATING ROOM	6,145,513.00	62,648.00
LABOR/DELIVERY ROOM	4,202,162.00	73,108.00
RESPIRATORY SERVICES	5,572,907.50	28,500.00
ANESTHESIA	1,143,178.00	16,113.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,731,340.00	43,446.00
RECOVERY ROOM	1,025,421.00	2,376.00
LABORATORY PATHOLOGIC	339,360.00	5,399.00
RADIOLOGY THERAPEUTIC	380,855.00	759.00
OCCUPATIONAL THERAPY	136,375.00	9,902.00
SPEECH PATHOLOGY	104,898.50	5,797.00
RENAL DIALYSIS	748,784.00	88,083.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,820.00	10,570.00
PSYCHIATRIC SERVICES	0.00	5,020.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	518,206.00	16,642.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,041,986.00	135,386.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	440,711.00	27,938.00
AUDIOLOGY	442,978.00	0.00
CARDIOLOGY	2,632,571.00	18,232.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	117,388.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	99,348.33	7,448.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	447,699.00	3,035.00
RECREATIONAL THERAPY	199.00	0.00
EDUCATION & TRAINING	99,306.00	672.00
OTHER THERAPEUTIC SVC	0.00	8,386.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,127,763.00	4,826.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	507.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,977.05	1,530.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	30,556.50

TOTAL ANCILLARY	65,028,880.59	1,322,103.56
TOTAL ACCOMODATIONS	19,260,892.52	1,120,030.69
TOTAL CHARGES	84,289,773.11	2,442,134.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
50	4410259017887	07/13/10 - 07/13/10	09/27/10	0.00	467.50	0.00	0.00	0.00
2581	4410259077164	07/04/10 - 07/04/10	09/27/10	0.00	315.00	0.00	0.00	0.00
2725	4410259077164	07/04/10 - 07/04/10	09/27/10	0.00	181.00	0.00	0.00	0.00
3021	4410259077164	07/04/10 - 07/04/10	09/27/10	0.00	50.00	0.00	0.00	0.00
2581	4410259101044	07/02/10 - 07/02/10	09/27/10	0.00	315.00	0.00	0.00	0.00
3010	4410259101044	07/02/10 - 07/02/10	09/27/10	0.00	207.00	0.00	0.00	0.00
3021	4410259101044	07/02/10 - 07/02/10	09/27/10	0.00	442.00	0.00	0.00	0.00
3068	4410259101044	07/02/10 - 07/02/10	09/27/10	0.00	84.00	0.00	0.00	0.00
2581	4410259158457	07/13/10 - 07/13/10	09/27/10	0.00	180.00	0.00	0.00	0.00
3021	4410259158457	07/13/10 - 07/13/10	09/27/10	0.00	50.00	0.00	0.00	0.00
3021	4010263062393	07/26/10 - 07/26/10	10/04/10	0.00	54.00	0.00	0.00	0.00
615	2311007000004	07/24/10 - 07/28/10	01/17/11	0.00	2,595.00	0.00	0.00	0.00
615	1111158001863	05/11/11 - 05/14/11	07/11/11	0.00	2,915.00	0.00	0.00	0.00
615	2311231000025	04/30/11 - 05/13/11	10/31/11	0.00	5,718.00	0.00	0.00	0.00
615	1111227007951	11/05/10 - 11/11/10	11/07/11	0.00	2,699.00	0.00	0.00	0.00
-1	9711320963072	10/08/10 - 10/11/10	12/05/11	0.00	0.00	0.00	0.00	0.00
615	9711361962054	06/03/11 - 06/11/11	01/09/12	0.00	2,915.00	0.00	0.00	0.00
615	9812019000658	05/05/11 - 05/10/11	03/19/12	0.00	2,915.00	0.00	0.00	0.00
615	9712150981022	03/11/11 - 06/07/11	06/04/12	0.00	2,915.00	0.00	0.00	0.00
615	5212206000090	07/06/10 - 07/15/10	07/30/12	0.00	5,539.00	0.00	0.00	0.00
TOTAL				0.00	30,556.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,283,979.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,281,675.75	CONTRACTUAL ALLOW	643,260.05
NON-COVERD CHARGES	2,304.00	TOTAL MEDICAID LIAB	638,415.70
		LESS: COB	638,415.70
		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	28	0	26,208.00	2,226.00
ROUTINE NURSERY	6	0	2,601.00	78.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	34	0	28,809.00	2,304.00
SPECIAL CARE SERVICES				
CCU	8	0	11,282.00	0.00
ICU	1	0	2,321.00	0.00
NICU	170	0	431,498.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	179	0	445,101.00	0.00
TOTAL ACCOMODATIONS	213	0	473,910.00	2,304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,191.50	0.00	OTHER LAB	2,776.00	0.00
MED/SURG SUPPLY	182,696.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,170.00	0.00	EDUCATION & TRAINING	2,832.00	0.00
RADIOLOGY-DIAGNOSTIC	15,951.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,244.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	998.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,573.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	94,364.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,460.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,140.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,575.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	673.00	0.00	INJECTABLE DRUGS	178.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,003.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	11,037.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,464.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,392.00	0.00			
CARDIOLOGY	29,053.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	995.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	807,765.75	0.00
TOTAL ACCOMODATIONS	473,910.00	2,304.00
TOTAL CHARGES	1,281,675.75	2,304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,948,200.66	ADJUSTMENTS	1,146,248.23
COVERED CHARGES	21,091,299.27	CONTRACTUAL ALLOW	16,814,408.38
NON-COVERD CHARGES	2,856,901.39	TOTAL MEDICAID LIAB	4,276,890.89
		LESS: COB	18,056.65
		LESS: COPAYMENT	8,819.80
		REIMBURSEMENT	4,250,014.44
		ALL OTHER	3,655,353.36
		FEE SCHEDULE-LAB	314,570.93
		INJECTABLE DRUGS	280,090.15

TOTAL NUMBER OF CLAIMS 8,720

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	821,744.97	2,768.00
MED/SURG SUPPLY	477,159.77	970.00
LABORATORY-GENERAL	0.00	604.61
RADIOLOGY-DIAGNOSTIC	1,065,403.00	33,417.00
CT SCAN	2,911,369.00	384,359.00
PHYSICAL THERAPY	32,791.00	9,512.00
EKG/ECG	159,900.00	1,534.00
IV THERAPY	203,110.00	2,067.00
OPERATING ROOM	946,768.00	192,527.00
LABOR/DELIVERY ROOM	165,490.00	0.00
RESPIRATORY SERVICES	139,464.00	16,152.00
ANESTHESIA	321,984.00	8,540.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,480,290.00	51,366.00
RECOVERY ROOM	252,848.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	564,404.00	407,815.00
OCCUPATIONAL THERAPY	14,316.00	9,571.00
SPEECH PATHOLOGY	7,758.00	4,165.00
RENAL DIALYSIS	0.00	19,172.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	123,454.00	6,392.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,180,270.00	186,126.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	59,117.00	19,235.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	530,945.00	6,300.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	632,119.00	157,590.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,727.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	336,010.14	6,424.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	179,513.00	8,768.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	658.00	374.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,227,374.64	524,408.70
MRI SERVICES	771,416.00	99,303.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,469,895.75	696,701.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	739.33

TOTAL ANCILLARY	21,091,299.27	2,856,901.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,091,299.27	2,856,901.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3018	4010253056355	07/02/10 - 07/02/10	09/27/10	0.00	176.00	0.00	0.00	0.00
3050	4010253056355	07/02/10 - 07/02/10	09/27/10	0.00	120.00	0.00	0.00	0.00
3060	4010253056355	07/02/10 - 07/02/10	09/27/10	0.00	203.00	0.00	0.00	0.00
3060	4010253056355	07/03/10 - 07/03/10	09/27/10	0.00	119.00	0.00	0.00	0.00
3202	5911096000841	01/24/11 - 01/24/11	04/11/11	0.00	46.55	0.00	0.00	0.00
3021	5911161000049	05/19/11 - 05/19/11	06/13/11	0.00	74.78	0.00	0.00	0.00
TOTAL				0.00	739.33	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	374,167.60	ADJUSTMENTS	0.00
COVERED CHARGES	317,424.10	CONTRACTUAL ALLOW	106,382.53
NON-COVERD CHARGES	56,743.50	TOTAL MEDICAID LIAB	211,041.57
		LESS: COB	210,930.83
		LESS: COPAYMENT	110.74
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	128

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,596.75	375.00
MED/SURG SUPPLY	4,989.00	3,514.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,396.00	335.00
CT SCAN	22,468.00	7,205.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,374.00	0.00
IV THERAPY	4,183.00	0.00
OPERATING ROOM	29,045.00	6,364.00
LABOR/DELIVERY ROOM	15,225.00	0.00
RESPIRATORY SERVICES	1,770.00	509.00
ANESTHESIA	6,229.00	8,578.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	67,586.00	2,013.00
RECOVERY ROOM	9,536.00	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	243.00	56.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,379.00	4,232.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,775.00	5,320.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,827.00	282.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,065.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,603.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,675.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,660.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	62,813.04	6,332.00
MRI SERVICES	11,889.00	3,447.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	97.25	1,884.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	6,297.00

TOTAL ANCILLARY	317,424.10	56,743.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	317,424.10	56,743.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2550	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	375.00	0.00	7,962.50	0.00
2581	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	45.00	0.00	7,962.50	0.00
3018	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	176.00	0.00	7,962.50	0.00
3050	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	120.00	0.00	7,962.50	0.00
3520	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	2,350.00	0.00	7,962.50	0.00
3520	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	2,469.00	0.00	7,962.50	0.00
4501	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	282.00	0.00	7,962.50	0.00
4501	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	164.00	0.00	7,962.50	0.00
3018	4410259014662	07/12/10 - 07/12/10	09/27/10	0.00	316.00	0.00	7,962.50	0.00
TOTAL				0.00	6,297.00	0.00	71,662.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	937,569.91	ADJUSTMENTS	6,639.68
COVERED CHARGES	900,112.16	CONTRACTUAL ALLOW	859,439.24
NON-COVERD CHARGES	37,457.75	TOTAL MEDICAID LIAB	40,672.92
		LESS: COB	0.00
		LESS: COPAYMENT	1,002.00
		REIMBURSEMENT	39,670.92

TOTAL NUMBER OF CLAIMS 731

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,909.00	114.00
MED/SURG SUPPLY	4,196.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,582.00	0.00
CT SCAN	62,570.00	2,160.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,844.00	0.00
IV THERAPY	3,846.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,584.00	509.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	495,382.00	3,659.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	805.00	116.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	56,350.00	4,829.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,710.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	924.16	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	20,365.00	829.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	152,924.00	21,507.00
MRI SERVICES	10,121.00	2,915.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	819.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	900,112.16	37,457.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	900,112.16	37,457.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,763.50	ADJUSTMENTS	0.00
COVERED CHARGES	17,444.25	CONTRACTUAL ALLOW	10,569.87
NON-COVERD CHARGES	1,319.25	TOTAL MEDICAID LIAB	6,874.38
		LESS: COB	6,853.38
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	301.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,871.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,793.00	436.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,990.00	24.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	97.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	455.00	762.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,444.25	1,319.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,444.25	1,319.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,992,911.09	ADJUSTMENTS	315,660.99
COVERED CHARGES	6,102,939.34	CONTRACTUAL ALLOW	5,276,780.66
NON-COVERD CHARGES	889,971.75	TOTAL MEDICAID LIAB	826,158.68
		LESS: COB	0.00
		LESS: COPAYMENT	1,811.01
		REIMBURSEMENT	824,347.67

TOTAL NUMBER OF CLAIMS 162

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,962.50	795.00
MED/SURG SUPPLY	1,041,976.87	907.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,063.00	12,326.00
CT SCAN	96,051.00	8,174.00
PHYSICAL THERAPY	3,338.00	117.00
EKG/ECG	10,839.00	0.00
IV THERAPY	73,700.00	0.00
OPERATING ROOM	223,521.00	14,501.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,466.00	0.00
ANESTHESIA	18,704.00	327.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,293.00	120.00
RECOVERY ROOM	15,522.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,384,416.00	489,589.00
OCCUPATIONAL THERAPY	3,588.00	67.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,025.00	2,736.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,401.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,905.00	3,156.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	40,088.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	212,396.00	29,152.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,287.72	1,442.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	68,137.00	13,608.00
MRI SERVICES	0.00	9,762.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,680,259.25	303,192.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,102,939.34	889,971.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,102,939.34	889,971.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL
PO BOX 406163
ATLANTA,GA 30384-6163

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,057,553.88	ADJUSTMENTS	779,591.23
COVERED CHARGES	18,766,351.47	CONTRACTUAL ALLOW	14,252,338.76
NON-COVERD CHARGES	291,202.41	TOTAL MEDICAID LIAB	4,514,012.71
		LESS: COB	105,650.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,408,361.86

TOTAL NUMBER OF ADMISSIONS 738

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,954	28	1,559,084.00	114,806.00
ROUTINE NURSERY	174	0	101,689.00	3,080.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,128	28	1,660,773.00	117,886.00
SPECIAL CARE SERVICES				
CCU	400	3	801,475.00	6,261.00
ICU	119	0	248,353.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	519	3	1,049,828.00	6,261.00
TOTAL ACCOMODATIONS	2,647	31	2,710,601.00	124,147.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,484,059.57	0.00
MED/SURG SUPPLY	1,252,785.09	848.20
LABORATORY-GENERAL	3,105,309.75	2,333.25
RADIOLOGY-DIAGNOSTIC	403,461.50	884.50
CT SCAN	772,423.00	15,474.00
PHYSICAL THERAPY	55,502.50	0.00
EKG/ECG	171,771.00	0.00
IV THERAPY	32,386.00	65.00
OPERATING ROOM	1,045,757.25	0.00
LABOR/DELIVERY ROOM	352,695.00	0.00
RESPIRATORY SERVICES	743,134.50	3,354.00
ANESTHESIA	166,882.00	0.00
GI SERVICES	74,847.00	0.00
EMERGENCY ROOM	617,406.00	114.00
RECOVERY ROOM	59,009.00	0.00
LABORATORY PATHOLOGIC	79,020.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,223.25	0.00
SPEECH PATHOLOGY	13,924.00	0.00
RENAL DIALYSIS	49,994.00	31,926.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,068.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	139,261.75	4,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	134,421.23	20,568.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	197,841.00	7,161.00
AUDIOLOGY	640.00	0.00
CARDIOLOGY	869,818.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	29,578.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	54,754.27	730.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	89,462.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,738.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	186,377.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	66,320.00
INJECTABLE DRUGS	2,840,937.56	11,038.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,055,750.47	167,055.41
TOTAL ACCOMODATIONS	2,710,601.00	124,147.00
TOTAL CHARGES	18,766,351.47	291,202.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	250,148.71	ADJUSTMENTS	0.00
COVERED CHARGES	246,516.96	CONTRACTUAL ALLOW	106,463.84
NON-COVERD CHARGES	3,631.75	TOTAL MEDICAID LIAB	140,053.12
		LESS: COB	140,053.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	45	0	35,730.00	2,268.00
ROUTINE NURSERY	4	2	2,008.00	1,004.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	49	2	37,738.00	3,272.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	4,174.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	4,174.00	0.00
TOTAL ACCOMODATIONS	51	2	41,912.00	3,272.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,041.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,025.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	31,098.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,330.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,456.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	644.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,323.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	517.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,914.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,125.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,478.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,804.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,017.50	0.00	INJECTABLE DRUGS	36,265.66	258.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,404.31	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,320.00	101.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	792.00	0.00			

TOTAL ANCILLARY	204,604.96	359.75
TOTAL ACCOMODATIONS	41,912.00	3,272.00
TOTAL CHARGES	246,516.96	3,631.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,764,978.96	ADJUSTMENTS	364,216.19
COVERED CHARGES	10,454,493.19	CONTRACTUAL ALLOW	8,584,463.92
NON-COVERD CHARGES	1,310,485.77	TOTAL MEDICAID LIAB	1,870,029.27
		LESS: COB	4,806.89
		LESS: COPAYMENT	4,329.11
		REIMBURSEMENT	1,860,893.27
		ALL OTHER	1,663,870.41
		FEE SCHEDULE-LAB	157,257.28
		INJECTABLE DRUGS	39,765.58

TOTAL NUMBER OF CLAIMS 4,205

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464,175.07	2,869.53
MED/SURG SUPPLY	459,874.62	46,021.90
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	760,974.75	8,792.25
CT SCAN	1,090,621.00	78,672.00
PHYSICAL THERAPY	23,623.50	12,954.75
EKG/ECG	176,875.00	0.00
IV THERAPY	53,197.00	256.00
OPERATING ROOM	934,843.52	216,797.04
LABOR/DELIVERY ROOM	36,063.00	5,514.00
RESPIRATORY SERVICES	100,051.00	505.75
ANESTHESIA	218,088.00	1,424.00
GI SERVICES	31,507.00	6,831.00
EMERGENCY ROOM	1,578,751.00	14,100.00
RECOVERY ROOM	143,715.00	640.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	25,468.00	7,390.25
SPEECH PATHOLOGY	1,357.00	2,783.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,456.00	764.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	400,730.00	26,218.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	52,812.22	6,855.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	160,175.00	24,842.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	282,336.00	110,648.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	58,682.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	192,812.36	13,236.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	85,435.50	17,828.25
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,870.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,511,467.40	488,165.17
MRI SERVICES	277,096.00	23,818.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	20,720.00
INJECTABLE DRUGS	319,305.75	167,967.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,454,493.19	1,310,485.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,454,493.19	1,310,485.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	362,980.11	ADJUSTMENTS	0.00
COVERED CHARGES	304,573.44	CONTRACTUAL ALLOW	157,217.81
NON-COVERD CHARGES	58,406.67	TOTAL MEDICAID LIAB	147,355.63
		LESS: COB	147,292.63
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 107

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,478.94	1,674.75
MED/SURG SUPPLY	10,802.80	0.00
LABORATORY-GENERAL	0.00	27.00
RADIOLOGY-DIAGNOSTIC	19,050.50	0.00
CT SCAN	12,370.00	11,706.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,955.00	0.00
IV THERAPY	2,986.00	0.00
OPERATING ROOM	37,459.00	5,916.00
LABOR/DELIVERY ROOM	0.00	1,451.00
RESPIRATORY SERVICES	2,178.00	263.50
ANESTHESIA	9,830.00	0.00
GI SERVICES	5,750.00	0.00
EMERGENCY ROOM	46,893.00	2,028.00
RECOVERY ROOM	8,861.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,686.00	2,939.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	212.00	48.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,504.25	2,473.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,131.00	846.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,058.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,200.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,706.00	759.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,334.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	128.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	78,865.00	12,929.25
MRI SERVICES	9,368.00	3,851.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,894.20	11,365.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	304,573.44	58,406.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	304,573.44	58,406.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	726,499.73	ADJUSTMENTS	3,618.98
COVERED CHARGES	669,005.85	CONTRACTUAL ALLOW	643,332.20
NON-COVERD CHARGES	57,493.88	TOTAL MEDICAID LIAB	25,673.65
		LESS: COB	938.40
		LESS: COPAYMENT	840.03
		REIMBURSEMENT	23,895.22

TOTAL NUMBER OF CLAIMS 448

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,171.32	0.00
MED/SURG SUPPLY	8,249.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,768.25	0.00
CT SCAN	72,776.00	4,786.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	16,787.00	0.00
IV THERAPY	6,555.00	0.00
OPERATING ROOM	446.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,303.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	258,753.00	384.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,906.75	1,952.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,791.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,700.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,418.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	193,363.50	43,586.50
MRI SERVICES	6,583.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	146.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,224.23	4,847.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	669,005.85	57,493.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	669,005.85	57,493.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,281.64	ADJUSTMENTS	0.00
COVERED CHARGES	17,665.14	CONTRACTUAL ALLOW	8,616.82
NON-COVERD CHARGES	1,616.50	TOTAL MEDICAID LIAB	9,048.32
		LESS: COB	9,039.32
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181.04	352.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	167.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,520.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,589.75	1,017.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	146.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,106.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	617.50	247.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,665.14	1,616.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,665.14	1,616.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	698,639.81	ADJUSTMENTS	15,134.79
COVERED CHARGES	651,306.32	CONTRACTUAL ALLOW	543,766.97
NON-COVERD CHARGES	47,333.49	TOTAL MEDICAID LIAB	107,539.35
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	107,497.35

TOTAL NUMBER OF CLAIMS 22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,197.82	174.00
MED/SURG SUPPLY	182,319.47	3,785.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,814.50	707.00
CT SCAN	6,608.00	2,131.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,019.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	251,708.00	16,272.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,142.25	392.00
ANESTHESIA	49,254.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,601.00	0.00
RECOVERY ROOM	14,607.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	17,135.00	0.00
OTHER IMAGING SERVICE	3,459.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,018.00	719.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,156.50	15,783.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,664.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,543.25	1,821.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,059.28	5,547.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	651,306.32	47,333.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	651,306.32	47,333.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,759,697.17	ADJUSTMENTS	14,619.28
COVERED CHARGES	2,697,579.67	CONTRACTUAL ALLOW	1,887,960.77
NON-COVERD CHARGES	62,117.50	TOTAL MEDICAID LIAB	809,618.90
		LESS: COB	4,590.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	805,027.97

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	510	0	418,908.00	52,991.00
ROUTINE NURSERY	37	0	14,844.00	0.00
SWING BED	0	1	0.00	52.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	547	1	433,752.00	53,043.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	23	0	31,832.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	23	0	31,832.00	0.00
TOTAL ACCOMODATIONS	570	1	465,584.00	53,043.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	549,611.00	2,430.00
MED/SURG SUPPLY	314,799.75	0.00
LABORATORY-GENERAL	328,239.50	0.00
RADIOLOGY-DIAGNOSTIC	33,195.00	0.00
CT SCAN	123,516.50	0.00
PHYSICAL THERAPY	7,559.50	0.00
EKG/ECG	11,931.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	168,177.50	0.00
LABOR/DELIVERY ROOM	12,892.00	0.00
RESPIRATORY SERVICES	107,933.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	550.00	0.00
EMERGENCY ROOM	114,099.00	0.00
RECOVERY ROOM	5,623.50	0.00
LABORATORY PATHOLOGIC	1,221.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,025.50	0.00
SPEECH PATHOLOGY	808.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	97.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,330.00	0.00
BLOOD	17,752.50	0.00
BLOOD STORAGE & PRO.	11,626.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	187.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,004.50	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/OBSERV. RM	29,522.17	6,457.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,377.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,235.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	9,468.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	314,400.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,231,995.67	9,074.50
TOTAL ACCOMODATIONS	465,584.00	53,043.00
TOTAL CHARGES	2,697,579.67	62,117.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,052.26	ADJUSTMENTS	0.00
COVERED CHARGES	44,987.26	CONTRACTUAL ALLOW	23,900.29
NON-COVERD CHARGES	65.00	TOTAL MEDICAID LIAB	21,086.97
		LESS: COB	21,086.97
		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	7	0	6,062.00	0.00
ROUTINE NURSERY	5	0	1,970.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	8,032.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	8,032.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,807.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,926.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,542.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,903.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	404.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	407.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,761.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	968.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	65.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	235.50	0.00			

TOTAL ANCILLARY	36,955.26	65.00
TOTAL ACCOMODATIONS	8,032.00	0.00
TOTAL CHARGES	44,987.26	65.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,765,350.74	ADJUSTMENTS	21,615.39
COVERED CHARGES	3,143,237.30	CONTRACTUAL ALLOW	2,464,147.83
NON-COVERD CHARGES	622,113.44	TOTAL MEDICAID LIAB	679,089.47
		LESS: COB	1,044.48
		LESS: COPAYMENT	2,703.00
		REIMBURSEMENT	675,341.99
		ALL OTHER	574,873.53
		FEE SCHEDULE-LAB	98,776.04
		INJECTABLE DRUGS	1,692.42

TOTAL NUMBER OF CLAIMS 2,902

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,304.14	76,900.10
MED/SURG SUPPLY	123,297.34	563.62
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203,080.50	4,801.50
CT SCAN	175,700.50	121,275.50
PHYSICAL THERAPY	1,013.50	2,913.50
EKG/ECG	31,490.00	2,056.00
IV THERAPY	255.00	53.00
OPERATING ROOM	205,934.50	70,571.50
LABOR/DELIVERY ROOM	5,931.00	0.00
RESPIRATORY SERVICES	23,897.00	2,508.00
ANESTHESIA	262.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	819,543.50	9,972.00
RECOVERY ROOM	11,920.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	749.00
SPEECH PATHOLOGY	0.00	924.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	194.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	166,698.50	16,461.00
BLOOD	5,280.00	0.00
BLOOD STORAGE & PRO.	1,342.50	6,708.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	29,779.50	12,201.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	56,701.00	10,798.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	114,596.38	15,472.82

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	37,055.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	5,945.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	862,466.30	178,449.91
MRI SERVICES	74,594.00	7,386.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	177.50	162.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,917.14	74,181.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,143,237.30	621,247.44
TOTAL ACCOMODATIONS	0.00	866.00
TOTAL CHARGES	3,143,237.30	622,113.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,400.13	ADJUSTMENTS	0.00
COVERED CHARGES	47,300.42	CONTRACTUAL ALLOW	6,766.80
NON-COVERD CHARGES	19,099.71	TOTAL MEDICAID LIAB	40,533.62
		LESS: COB	40,500.79
		LESS: COPAYMENT	32.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,410.00	2,702.50
MED/SURG SUPPLY	1,323.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	857.00	0.00
CT SCAN	7,196.00	6,916.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	484.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,373.50	1,450.00
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	9,232.50	449.50
RECOVERY ROOM	163.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,356.00	2,178.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	154.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,597.17	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,048.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	121.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,433.50	2,103.21
MRI SERVICES	0.00	2,659.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	825.50	366.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	47,300.42	19,099.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,300.42	19,099.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,319.62	ADJUSTMENTS	429.00
COVERED CHARGES	424,895.12	CONTRACTUAL ALLOW	396,143.12
NON-COVERD CHARGES	47,424.50	TOTAL MEDICAID LIAB	28,752.00
		LESS: COB	0.00
		LESS: COPAYMENT	708.03
		REIMBURSEMENT	28,043.97

TOTAL NUMBER OF CLAIMS 579

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,411.00	5,966.00
MED/SURG SUPPLY	3,902.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,804.50	217.00
CT SCAN	8,317.50	20,066.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	968.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	363.00	0.00
RESPIRATORY SERVICES	1,949.00	65.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	233,570.50	412.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	97.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	29,283.00	10,656.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,497.62	626.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	726.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	103,310.00	6,572.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,792.50	2,746.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	424,895.12	47,424.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	424,895.12	47,424.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,877.50	ADJUSTMENTS	0.00
COVERED CHARGES	5,133.50	CONTRACTUAL ALLOW	3,198.20
NON-COVERD CHARGES	744.00	TOTAL MEDICAID LIAB	1,935.30
		LESS: COB	1,923.30
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387.00	234.00
MED/SURG SUPPLY	74.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	194.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	121.00	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	3,011.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,346.50	510.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,133.50	744.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,133.50	744.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,277.39	ADJUSTMENTS	0.00
COVERED CHARGES	56,158.39	CONTRACTUAL ALLOW	47,046.53
NON-COVERD CHARGES	10,119.00	TOTAL MEDICAID LIAB	9,111.86
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,105.86

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,561.50	0.00
MED/SURG SUPPLY	31,809.57	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	195.00	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	9,526.00	7,358.00
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	1,242.00	0.00
RECOVERY ROOM	1,059.50	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 SERVICE	726.00	726.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,168.82	89.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	718.50	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,151.50	1,945.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	56,158.39	10,119.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,158.39	10,119.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
PO BOX 919
HINESVILLE,GA 31310-0919

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/10 THROUGH 11/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	296,609.50	ADJUSTMENTS	9,518.25
COVERED CHARGES	295,259.50	CONTRACTUAL ALLOW	164,933.41
NON-COVERD CHARGES	1,350.00	TOTAL MEDICAID LIAB	130,326.09
		LESS: COB	2,127.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	128,198.93

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	106	0	40,202.00	1,350.00
ROUTINE NURSERY	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	106	0	40,202.00	1,350.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	106	0	40,202.00	1,350.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,868.75	0.00
MED/SURG SUPPLY	33,680.75	0.00
LABORATORY-GENERAL	34,648.50	0.00
RADIOLOGY-DIAGNOSTIC	5,218.50	0.00
CT SCAN	12,655.50	0.00
PHYSICAL THERAPY	187.50	0.00
EKG/ECG	4,530.00	0.00
IV THERAPY	3,445.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,695.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,718.00	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 SERVICE	817.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,927.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,486.50	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/OBSERV. RM	4,950.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,228.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	255,057.50	0.00
TOTAL ACCOMODATIONS	40,202.00	1,350.00
TOTAL CHARGES	295,259.50	1,350.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	571,115.25	ADJUSTMENTS	9,293.36
COVERED CHARGES	525,269.00	CONTRACTUAL ALLOW	307,145.37
NON-COVERD CHARGES	45,846.25	TOTAL MEDICAID LIAB	218,123.63
		LESS: COB	30.00
		LESS: COPAYMENT	1,046.94
		REIMBURSEMENT	217,046.69
		ALL OTHER	189,212.69
		FEE SCHEDULE-LAB	27,803.85
		INJECTABLE DRUGS	30.15

TOTAL NUMBER OF CLAIMS 809

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,414.50	1,422.50
MED/SURG SUPPLY	10,074.25	435.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,201.50	1,573.25
CT SCAN	68,045.25	5,456.00
PHYSICAL THERAPY	359.25	93.75
EKG/ECG	12,254.00	534.25
IV THERAPY	9,815.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,192.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	154,957.50	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	190.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,619.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,936.00	895.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,405.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,160.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,219.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,868.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	120,909.50	29,372.50
MRI SERVICES	7,582.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64.00	6,063.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	525,269.00	45,846.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	525,269.00	45,846.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31.75	ADJUSTMENTS	0.00
COVERED CHARGES	31.75	CONTRACTUAL ALLOW	28.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2.94
		LESS: COB	0.00
		LESS: COPAYMENT	2.94
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31.75	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,883.75	ADJUSTMENTS	47.00
COVERED CHARGES	68,417.25	CONTRACTUAL ALLOW	61,817.25
NON-COVERD CHARGES	1,466.50	TOTAL MEDICAID LIAB	6,600.00
		LESS: COB	0.41
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	6,362.59

TOTAL NUMBER OF CLAIMS 132

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,602.25	0.00
MED/SURG SUPPLY	1,802.75	123.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,899.50	0.00
CT SCAN	1,154.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	755.00	0.00
IV THERAPY	757.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,121.75	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	443.25	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	441.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	738.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,089.50	902.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	68,417.25	1,466.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,417.25	1,466.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,871.75	ADJUSTMENTS	4,387.30
COVERED CHARGES	47,572.75	CONTRACTUAL ALLOW	34,410.85
NON-COVERD CHARGES	299.00	TOTAL MEDICAID LIAB	13,161.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,161.90

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,730.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	151.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,301.50	299.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	47,572.75	299.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,572.75	299.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH HOSPITAL
PO BOX 5888
VALDOSTA,GA 31603-5888

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,266,587.53	ADJUSTMENTS	67,531.12
COVERED CHARGES	1,259,242.71	CONTRACTUAL ALLOW	596,031.46
NON-COVERD CHARGES	7,344.82	TOTAL MEDICAID LIAB	663,211.25
		LESS: COB	3,391.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	659,819.31

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	236	0	125,080.00	3,824.00
ROUTINE NURSERY	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	236	0	125,080.00	3,824.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	74	0	100,086.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	74	0	100,086.00	0.00
TOTAL ACCOMODATIONS	310	0	225,166.00	3,824.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,303.99	0.00
MED/SURG SUPPLY	321,286.47	681.72
LABORATORY-GENERAL	102,632.47	453.20
RADIOLOGY-DIAGNOSTIC	23,782.95	0.00
CT SCAN	42,284.25	0.00
PHYSICAL THERAPY	23,213.70	0.00
EKG/ECG	3,832.55	0.00
IV THERAPY	6,984.05	1,531.45
OPERATING ROOM	56,952.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29,923.65	0.00
ANESTHESIA	3,513.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	53,731.50	269.45
RECOVERY ROOM	9,394.00	0.00
LABORATORY PATHOLOGIC	93.20	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	64.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,224.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,415.55	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,725.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,981.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	298.80	0.00
OTHER THERAPEUTIC SVC	0.00	585.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,439.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,034,076.71	3,520.82
TOTAL ACCOMODATIONS	225,166.00	3,824.00
TOTAL CHARGES	1,259,242.71	7,344.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,708,405.70	ADJUSTMENTS	96,346.83
COVERED CHARGES	1,468,385.44	CONTRACTUAL ALLOW	1,040,466.82
NON-COVERD CHARGES	240,020.26	TOTAL MEDICAID LIAB	427,918.62
		LESS: COB	272.44
		LESS: COPAYMENT	1,722.00
		REIMBURSEMENT	425,924.18
		ALL OTHER	399,859.40
		FEE SCHEDULE-LAB	25,529.32
		INJECTABLE DRUGS	535.46
		TOTAL NUMBER OF CLAIMS	1,523

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,749.00	1,277.59
MED/SURG SUPPLY	210,869.38	22,513.27
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96,303.45	1,820.90
CT SCAN	79,585.67	28,260.00
PHYSICAL THERAPY	359.15	37.75
EKG/ECG	18,487.35	323.90
IV THERAPY	35,942.95	2,918.80
OPERATING ROOM	129,502.05	66,977.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,629.05	2,303.50
ANESTHESIA	15,038.85	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	408,815.80	6,007.20
RECOVERY ROOM	46,441.70	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	65.00	519.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	63,397.25	2,349.45
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,367.20	2,551.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,725.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	32,657.55	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	39,441.15	1,985.15

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,155.05	681.30
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	49.80	1,220.10
OTHER THERAPEUTIC SVC	0.00	6,459.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	157,780.67	42,877.07
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	69.30
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,022.37	48,843.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	24.90

TOTAL ANCILLARY	1,468,385.44	240,020.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,468,385.44	240,020.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9940	5911273001089	04/13/11 - 04/13/11	10/03/11	0.00	24.90	0.00	0.00	0.00
TOTAL				0.00	24.90	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,740.92	ADJUSTMENTS	0.00
COVERED CHARGES	20,350.40	CONTRACTUAL ALLOW	11,682.13
NON-COVERD CHARGES	2,390.52	TOTAL MEDICAID LIAB	8,668.27
		LESS: COB	8,632.27
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,364.68	0.00	OTHER LAB	0.00	560.35
MED/SURG SUPPLY	1,947.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,380.05	190.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,541.00	1,438.25
EKG/ECG	485.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,088.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	341.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,571.60	166.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	273.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	230.62	34.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	777.25	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/OBSERV. RM	1,348.40	0.00			

TOTAL ANCILLARY	20,350.40	2,390.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,350.40	2,390.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	112,959.38	ADJUSTMENTS	320.64
COVERED CHARGES	105,737.36	CONTRACTUAL ALLOW	92,353.27
NON-COVERD CHARGES	7,222.02	TOTAL MEDICAID LIAB	13,384.09
		LESS: COB	0.00
		LESS: COPAYMENT	435.01
		REIMBURSEMENT	12,949.08

TOTAL NUMBER OF CLAIMS 242

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,887.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,380.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,463.90	0.00	OTHER THERAPEUTIC SVC	0.00	625.60
CT SCAN	2,196.80	2,196.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,497.65	2,589.00
EKG/ECG	809.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	852.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,464.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,202.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,981.12	1,810.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	105,737.36	7,222.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,737.36	7,222.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	409.84	ADJUSTMENTS	0.00
COVERED CHARGES	375.22	CONTRACTUAL ALLOW	256.79
NON-COVERD CHARGES	34.62	TOTAL MEDICAID LIAB	118.43
		LESS: COB	115.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	340.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34.62	34.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	375.22	34.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	375.22	34.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,209,451.55	ADJUSTMENTS	4,683,017.26
COVERED CHARGES	50,610,194.74	CONTRACTUAL ALLOW	33,634,742.61
NON-COVERD CHARGES	599,256.81	TOTAL MEDICAID LIAB	16,975,452.13
		LESS: COB	218,507.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,756,944.39

TOTAL NUMBER OF ADMISSIONS 1,800

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,306	18	5,254,681.00	40,211.00
ROUTINE NURSERY	963	0	543,474.50	8,800.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	5	0.00	0.00
TOTAL ROUTINE	9,269	23	5,798,155.50	49,011.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,395	0	1,979,505.00	0.00
NICU	835	0	943,296.00	0.00
PED ICU	58	0	82,302.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,288	0	3,005,103.00	0.00
TOTAL ACCOMODATIONS	11,557	23	8,803,258.50	49,011.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,435,472.45	14,365.88
MED/SURG SUPPLY	5,941,509.21	80,086.28
LABORATORY-GENERAL	6,358,485.28	18,396.88
RADIOLOGY-DIAGNOSTIC	1,091,046.17	3,472.00
CT SCAN	1,995,341.79	5,504.49
PHYSICAL THERAPY	456,112.99	0.00
EKG/ECG	521,408.75	0.00
IV THERAPY	216,433.00	1,954.00
OPERATING ROOM	2,403,276.11	7,384.30
LABOR/DELIVERY ROOM	867,032.34	3,731.95
RESPIRATORY SERVICES	3,089,773.24	30,244.00
ANESTHESIA	211,822.31	0.00
GI SERVICES	4,867.12	0.00
EMERGENCY ROOM	1,936,985.88	8,752.46
RECOVERY ROOM	408,749.78	321.54
LABORATORY PATHOLOGIC	167,215.45	0.00
RADIOLOGY THERAPEUTIC	180,752.05	0.00
OCCUPATIONAL THERAPY	88,993.68	0.00
SPEECH PATHOLOGY	122,974.73	0.00
RENAL DIALYSIS	114,591.00	48,611.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10,122.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	218,670.50	19,785.08
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,832,960.00	85,857.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	115,639.90	57,475.80
AUDIOLOGY	50,059.72	7,478.71
CARDIOLOGY	693,242.48	11,668.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	42,031.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	43,429.16	11,398.53

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	277,833.01	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	11,445.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	593,410.66	3,307.85
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	430.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,326,816.33	55,881.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	540.10
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	48,390.45
NO CC/INVALID REV CODE	0.00	3,639.50

TOTAL ANCILLARY	41,806,936.24	550,245.81
TOTAL ACCOMODATIONS	8,803,258.50	49,011.00
TOTAL CHARGES	50,610,194.74	599,256.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2590	4410259086513	07/17/10 - 07/17/10	09/27/10	0.00	100.00	0.00	0.00	0.00
3908	4410259086513	07/17/10 - 07/17/10	09/27/10	0.00	232.00	0.00	0.00	0.00
7200	4410259086513	07/17/10 - 07/17/10	09/27/10	0.00	3,052.85	0.00	0.00	0.00
2590	4410259158533	07/02/10 - 07/02/10	09/27/10	0.00	22.65	0.00	0.00	0.00
3908	4410259158533	07/02/10 - 07/02/10	09/27/10	0.00	232.00	0.00	0.00	0.00
TOTAL				0.00	3,639.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	369,708.09	ADJUSTMENTS	0.00
COVERED CHARGES	362,865.17	CONTRACTUAL ALLOW	128,330.68
NON-COVERD CHARGES	6,842.92	TOTAL MEDICAID LIAB	234,534.49
		LESS: COB	234,534.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	137	0	86,449.00	0.00
ROUTINE NURSERY	5	0	2,110.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	142	0	88,559.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	142	0	88,559.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,912.23	0.00
MED/SURG SUPPLY	45,838.00	0.00
LABORATORY-GENERAL	33,719.59	0.00
RADIOLOGY-DIAGNOSTIC	3,988.66	0.00
CT SCAN	8,712.00	0.00
PHYSICAL THERAPY	2,235.00	0.00
EKG/ECG	5,215.25	0.00
IV THERAPY	1,456.00	0.00
OPERATING ROOM	10,315.50	0.00
LABOR/DELIVERY ROOM	46,703.10	576.15
RESPIRATORY SERVICES	4,350.48	0.00
ANESTHESIA	7,714.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,433.00	0.00
RECOVERY ROOM	2,973.36	0.00
LABORATORY PATHOLOGIC	2,988.60	0.00
RADIOLOGY THERAPEUTIC	3,581.10	0.00
OCCUPATIONAL THERAPY	325.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	1,656.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,712.39	4,946.27
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,629.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,259.10	1,320.50
AUDIOLOGY	224.57	0.00
CARDIOLOGY	5,283.85	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,028.85	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,051.54	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	274,306.17	6,842.92
TOTAL ACCOMODATIONS	88,559.00	0.00
TOTAL CHARGES	362,865.17	6,842.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,391,732.65	ADJUSTMENTS	1,367,969.25
COVERED CHARGES	18,771,422.49	CONTRACTUAL ALLOW	13,535,946.44
NON-COVERD CHARGES	1,620,310.16	TOTAL MEDICAID LIAB	5,235,476.05
		LESS: COB	7,997.17
		LESS: COPAYMENT	29,561.20
		REIMBURSEMENT	5,197,917.68
		ALL OTHER	4,374,703.59
		FEE SCHEDULE-LAB	379,758.02
		INJECTABLE DRUGS	443,456.07

TOTAL NUMBER OF CLAIMS 15,089

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	995,566.98	21,230.48
MED/SURG SUPPLY	762,292.50	6,604.00
LABORATORY-GENERAL	0.00	175.50
RADIOLOGY-DIAGNOSTIC	923,381.36	14,430.32
CT SCAN	1,599,328.92	195,854.52
PHYSICAL THERAPY	81,531.80	28,271.82
EKG/ECG	161,263.85	1,340.90
IV THERAPY	465,280.00	5,160.00
OPERATING ROOM	1,079,651.53	129,699.42
LABOR/DELIVERY ROOM	2,568.00	0.00
RESPIRATORY SERVICES	195,507.76	9,123.49
ANESTHESIA	59,769.18	126.00
GI SERVICES	4,521.00	0.00
EMERGENCY ROOM	3,432,887.03	55,410.66
RECOVERY ROOM	387,369.40	1,020.18
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,027,501.10	30,841.10
OCCUPATIONAL THERAPY	29,304.84	8,861.00
SPEECH PATHOLOGY	891.49	3,130.27
RENAL DIALYSIS	1,032.00	2,688.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	518,185.35	46,522.88
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	722,164.80	47,431.19
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	93,897.00	3,488.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	164,959.25	4,472.40
AUDIOLOGY	596.49	0.00
CARDIOLOGY	234,770.34	15,694.39
AMBULATORY SURGERY	6,203.00	56.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	53,073.36	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	450,945.32	10,069.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	207,546.58	4,057.61
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	512.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,552,245.23	425,636.49
MRI SERVICES	865,475.79	41,359.91
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,691,711.24	500,076.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	14.50
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	6,950.95
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,771,422.49	1,620,310.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,771,422.49	1,620,310.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	172,166.82	ADJUSTMENTS	0.00
COVERED CHARGES	100,826.66	CONTRACTUAL ALLOW	43,571.94
NON-COVERD CHARGES	71,340.16	TOTAL MEDICAID LIAB	57,254.72
		LESS: COB	57,155.24
		LESS: COPAYMENT	99.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,826.50	483.65
MED/SURG SUPPLY	2,325.00	0.00
LABORATORY-GENERAL	0.00	48.00
RADIOLOGY-DIAGNOSTIC	3,860.14	390.42
CT SCAN	20,057.00	5,087.00
PHYSICAL THERAPY	1,199.00	1,702.00
EKG/ECG	399.30	0.00
IV THERAPY	5,410.00	0.00
OPERATING ROOM	2,940.40	5,935.60
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	580.28	0.00
ANESTHESIA	378.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,996.00	996.46
RECOVERY ROOM	2,451.36	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,673.94	4,850.08
OCCUPATIONAL THERAPY	333.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,004.90	1,502.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,844.44	1,283.78
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	232.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,570.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	677.48	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,550.50	1,032.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	573.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,265.33	2,850.00
MRI SERVICES	5,099.45	2,818.91
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,579.64	40,022.31
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	2,337.95
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	100,826.66	71,340.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	100,826.66	71,340.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	638,135.46	ADJUSTMENTS	7,050.13
COVERED CHARGES	609,828.90	CONTRACTUAL ALLOW	563,647.66
NON-COVERD CHARGES	28,306.56	TOTAL MEDICAID LIAB	46,181.24
		LESS: COB	57.23
		LESS: COPAYMENT	1,521.06
		REIMBURSEMENT	44,602.95

TOTAL NUMBER OF CLAIMS 826

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,343.32	0.00
MED/SURG SUPPLY	9,721.53	76.00
LABORATORY-GENERAL	0.00	138.00
RADIOLOGY-DIAGNOSTIC	38,311.24	195.21
CT SCAN	28,573.52	0.00
PHYSICAL THERAPY	0.00	247.00
EKG/ECG	4,236.60	0.00
IV THERAPY	12,190.00	0.00
OPERATING ROOM	2,533.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,557.98	0.00
ANESTHESIA	154.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	291,178.10	2,090.00
RECOVERY ROOM	1,807.18	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	19,360.88	0.00
OCCUPATIONAL THERAPY	961.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,104.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,096.00	164.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,436.49	1,336.17
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	113.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,063.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,675.98	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	107,024.63	17,516.06
MRI SERVICES	9,567.99	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	41,923.46	5,440.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	609,828.90	28,306.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	609,828.90	28,306.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,004.86	ADJUSTMENTS	0.00
COVERED CHARGES	6,522.86	CONTRACTUAL ALLOW	3,589.54
NON-COVERD CHARGES	1,482.00	TOTAL MEDICAID LIAB	2,933.32
		LESS: COB	2,921.32
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	531.79	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,098.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,207.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,522.86	1,482.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,522.86	1,482.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,856,467.48	ADJUSTMENTS	299,739.00
COVERED CHARGES	4,740,496.78	CONTRACTUAL ALLOW	3,708,608.70
NON-COVERD CHARGES	115,970.70	TOTAL MEDICAID LIAB	1,031,888.08
		LESS: COB	0.00
		LESS: COPAYMENT	3,011.66
		REIMBURSEMENT	1,028,876.42

TOTAL NUMBER OF CLAIMS 194

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,327.37	934.25
MED/SURG SUPPLY	264,105.00	44.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,691.51	2,245.75
CT SCAN	54,636.44	3,264.00
PHYSICAL THERAPY	0.00	733.00
EKG/ECG	2,347.40	0.00
IV THERAPY	158,783.32	0.00
OPERATING ROOM	153,285.60	9,279.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57,035.00	0.00
ANESTHESIA	7,406.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,334.95	380.00
RECOVERY ROOM	41,518.14	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,381,056.34	6,897.20
OCCUPATIONAL THERAPY	0.00	386.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	960.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	45,932.90	22,970.93
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,838.81	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,785.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,417.95	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,570.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	30,260.45	442.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,277.97	2,707.44
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,746.17	11,744.59
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,244,180.46	53,941.59
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,740,496.78	115,970.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,740,496.78	115,970.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,431.72	ADJUSTMENTS	0.00
COVERED CHARGES	20,431.72	CONTRACTUAL ALLOW	653.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	19,777.98
		LESS: COB	19,777.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER
710 CENTER ST
COLUMBUS,GA 31901-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,659.72	0.00
RADIOLOGY THERAPEUTIC	1,292.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,480.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,431.72	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,431.72	0.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	142,344,873.32	ADJUSTMENTS	10,496,969.64
COVERED CHARGES	140,284,734.78	CONTRACTUAL ALLOW	97,346,386.15
NON-COVERD CHARGES	2,060,138.54	TOTAL MEDICAID LIAB	42,938,348.63
		LESS: COB	489,015.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	42,449,333.40

TOTAL NUMBER OF ADMISSIONS 3,552

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17,882	33	12,116,280.00	468,864.00
ROUTINE NURSERY	795	0	548,930.00	24,000.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18,677	33	12,665,210.00	492,864.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,778	0	7,472,157.72	107.28
NICU	1,897	0	4,552,800.00	0.00
PED ICU	734	0	1,755,215.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,409	0	13,780,172.72	107.28
TOTAL ACCOMODATIONS	25,086	33	26,445,382.72	492,971.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,963,356.52	101,277.82
MED/SURG SUPPLY	14,909,060.36	171,868.00
LABORATORY-GENERAL	15,598,397.22	40,928.00
RADIOLOGY-DIAGNOSTIC	3,609,683.00	2,995.00
CT SCAN	4,486,788.00	110,772.00
PHYSICAL THERAPY	493,825.00	3,391.00
EKG/ECG	685,900.00	268.00
IV THERAPY	731,004.00	30,032.00
OPERATING ROOM	6,241,277.50	7,072.00
LABOR/DELIVERY ROOM	1,362,939.00	893.00
RESPIRATORY SERVICES	6,797,228.00	162,909.00
ANESTHESIA	1,137,764.00	705.00
GI SERVICES	34,193.00	0.00
EMERGENCY ROOM	3,826,144.00	33,409.00
RECOVERY ROOM	1,088,064.00	1,030.00
LABORATORY PATHOLOGIC	229,870.00	202.00
RADIOLOGY THERAPEUTIC	128,866.00	8,341.00
OCCUPATIONAL THERAPY	260,417.00	3,565.00
SPEECH PATHOLOGY	321,526.00	467.00
RENAL DIALYSIS	838,988.00	419,819.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	41,714.00
PSYCHIATRIC SERVICES	98,141.10	1,349.90
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	500,781.00	497.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,564,627.00	2,954.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	546,564.00	40,032.00
AUDIOLOGY	5,254.00	0.00
CARDIOLOGY	7,240,137.00	7,043.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,591.00	596.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,271,705.00	48,254.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	709,007.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	67.00	0.00
OTHER THERAPEUTIC SVC	0.00	308,724.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,575,608.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	707.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	8,732.00
INJECTABLE DRUGS	512,872.36	563.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	6,764.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	113,839,352.06	1,567,167.26
TOTAL ACCOMODATIONS	26,445,382.72	492,971.28
TOTAL CHARGES	140,284,734.78	2,060,138.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	513,126.85	ADJUSTMENTS	0.00
COVERED CHARGES	511,683.85	CONTRACTUAL ALLOW	384,671.19
NON-COVERD CHARGES	1,443.00	TOTAL MEDICAID LIAB	127,012.66
		LESS: COB	127,012.66
		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	45	0	30,825.00	0.00
ROUTINE NURSERY	2	0	500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	31,325.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	32	0	41,250.00	0.00
NICU	4	0	9,600.00	0.00
PED ICU	2	0	4,800.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	38	0	55,650.00	0.00
TOTAL ACCOMODATIONS	85	0	86,975.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,834.02	0.00	OTHER LAB	925.00	0.00
MED/SURG SUPPLY	46,631.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,315.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,432.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,443.00
CT SCAN	1,466.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	850.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	670.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,282.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,828.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	29,727.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,329.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,962.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,594.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	344.00	0.00	INJECTABLE DRUGS	13,994.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	939.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	748.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	354.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	801.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,164.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	731.00	0.00			

TOTAL ANCILLARY	424,708.85	1,443.00
TOTAL ACCOMODATIONS	86,975.00	0.00
TOTAL CHARGES	511,683.85	1,443.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,510,814.39	ADJUSTMENTS	2,088,254.97
COVERED CHARGES	35,804,613.11	CONTRACTUAL ALLOW	26,339,580.64
NON-COVERD CHARGES	3,706,201.28	TOTAL MEDICAID LIAB	9,465,032.47
		LESS: COB	41,641.68
		LESS: COPAYMENT	36,039.19
		REIMBURSEMENT	9,387,351.60
		ALL OTHER	7,685,529.23
		FEE SCHEDULE-LAB	1,124,320.06
		INJECTABLE DRUGS	577,502.31

TOTAL NUMBER OF CLAIMS 27,654

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,638,299.05	11,366.74
MED/SURG SUPPLY	1,632,574.90	52,341.00
LABORATORY-GENERAL	0.00	172.00
RADIOLOGY-DIAGNOSTIC	1,573,420.00	67,278.00
CT SCAN	1,954,765.00	234,784.00
PHYSICAL THERAPY	18,833.00	13,298.00
EKG/ECG	279,689.00	5,494.00
IV THERAPY	1,050,571.00	144,751.00
OPERATING ROOM	2,900,593.00	606,715.00
LABOR/DELIVERY ROOM	337,607.00	13,167.00
RESPIRATORY SERVICES	221,641.00	2,051.00
ANESTHESIA	752,346.00	1,169.00
GI SERVICES	43,735.00	5,618.00
EMERGENCY ROOM	3,867,731.00	47,748.00
RECOVERY ROOM	1,254,878.00	2,282.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	175,189.00	3,827.00
OCCUPATIONAL THERAPY	13,152.00	6,384.00
SPEECH PATHOLOGY	25,364.00	13,525.00
RENAL DIALYSIS	0.00	5,192.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,657,334.00	42,887.00
PSYCHIATRIC SERVICES	1,044.00	1,609.00
LITHOTRIPSY	13,980.00	0.00
OTHER IMAGING SERVICE	442,047.00	33,983.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	438,581.00	636.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	570,604.00	11,813.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,012,561.00	249,352.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	146,318.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,184,716.04	9,011.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	211,195.00	2,326.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	4,660.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,304,196.28	1,481,432.95
MRI SERVICES	45,293.00	38,876.00
PROFESSIONAL FEES	0.00	405.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	64.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,031,631.84	595,554.59
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,153.00

TOTAL ANCILLARY	35,804,613.11	3,706,201.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,804,613.11	3,706,201.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
245	5211059000801	12/04/10 - 12/04/10	04/18/11	0.00	231.00	0.00	0.00	0.00
245	5211059000801	12/04/10 - 12/04/10	04/18/11	0.00	217.00	0.00	0.00	0.00
9928	5911312000785	08/17/11 - 08/17/11	11/14/11	0.00	705.00	0.00	0.00	0.00
TOTAL				0.00	1,153.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	203,232.45	ADJUSTMENTS	0.00
COVERED CHARGES	183,079.71	CONTRACTUAL ALLOW	139,893.40
NON-COVERD CHARGES	20,152.74	TOTAL MEDICAID LIAB	43,186.31
		LESS: COB	43,089.63
		LESS: COPAYMENT	96.68
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,922.62	0.00
MED/SURG SUPPLY	13,567.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,054.00	1,410.00
CT SCAN	18,949.00	4,144.00
PHYSICAL THERAPY	0.00	308.00
EKG/ECG	1,072.00	0.00
IV THERAPY	4,935.00	0.00
OPERATING ROOM	25,238.00	4,164.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,269.00	0.00
ANESTHESIA	6,456.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,722.00	1,382.00
RECOVERY ROOM	11,460.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	454.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,621.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,331.00	688.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,238.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	784.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,317.00	112.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,417.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,857.20	6,865.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,415.29	1,003.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	75.00

TOTAL ANCILLARY	183,079.71	20,152.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	183,079.71	20,152.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	5011143903004	04/04/11 - 04/04/11	06/13/11	0.00	75.00	0.00	1,646.00	0.00
TOTAL				0.00	75.00	0.00	1,646.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	904,161.65	ADJUSTMENTS	6,339.86
COVERED CHARGES	844,845.38	CONTRACTUAL ALLOW	800,807.89
NON-COVERD CHARGES	59,316.27	TOTAL MEDICAID LIAB	44,037.49
		LESS: COB	0.00
		LESS: COPAYMENT	1,569.14
		REIMBURSEMENT	42,468.35

TOTAL NUMBER OF CLAIMS 787

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,636.30	0.00
MED/SURG SUPPLY	18,162.00	267.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,742.00	830.00
CT SCAN	26,062.00	2,753.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,102.00	0.00
IV THERAPY	20,101.00	204.00
OPERATING ROOM	836.00	3,236.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,816.00	99.00
ANESTHESIA	557.00	0.00
GI SERVICES	15,939.00	0.00
EMERGENCY ROOM	488,120.00	1,420.00
RECOVERY ROOM	1,030.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	311.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,990.00	63.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,796.00	460.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,908.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,044.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,063.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	152,466.00	49,093.00
MRI SERVICES	2,725.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,439.08	891.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	844,845.38	59,316.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	844,845.38	59,316.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,905.57	ADJUSTMENTS	0.00
COVERED CHARGES	14,284.57	CONTRACTUAL ALLOW	12,746.76
NON-COVERD CHARGES	4,621.00	TOTAL MEDICAID LIAB	1,537.81
		LESS: COB	1,528.80
		LESS: COPAYMENT	9.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	919.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	272.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	972.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,083.00	3,743.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,394.00	450.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,510.00	408.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,053.00	20.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,284.57	4,621.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,284.57	4,621.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,504,419.39	ADJUSTMENTS	699,564.84
COVERED CHARGES	8,583,264.62	CONTRACTUAL ALLOW	6,862,136.87
NON-COVERD CHARGES	921,154.77	TOTAL MEDICAID LIAB	1,721,127.75
		LESS: COB	16,485.49
		LESS: COPAYMENT	1,134.00
		REIMBURSEMENT	1,703,508.26

TOTAL NUMBER OF CLAIMS 307

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622,390.62	1,134.47
MED/SURG SUPPLY	3,029,584.00	273,858.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420,771.00	44,791.00
CT SCAN	53,308.00	28,394.00
PHYSICAL THERAPY	0.00	311.00
EKG/ECG	36,265.00	0.00
IV THERAPY	141,477.00	39,984.00
OPERATING ROOM	480,817.00	244,960.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,445.00	99.00
ANESTHESIA	90,280.00	0.00
GI SERVICES	759.00	0.00
EMERGENCY ROOM	71,107.00	3,488.00
RECOVERY ROOM	100,820.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,040.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	311.00
RENAL DIALYSIS	0.00	6,850.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,133.00	151.00
PSYCHIATRIC SERVICES	47.00	69.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,628.00	1,172.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,022.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,468.00	231.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,070,688.00	186,778.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	596.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	396,247.00	16,973.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	81,336.00	7,187.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	279,769.00	49,236.80
MRI SERVICES	17,476.00	8,675.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	593,791.00	6,501.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,583,264.62	921,154.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,583,264.62	921,154.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
PO BOX 116602
ATLANTA,GA 30368-6602

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,141,841.88	ADJUSTMENTS	39,800.21
COVERED CHARGES	2,071,561.88	CONTRACTUAL ALLOW	1,030,183.88
NON-COVERD CHARGES	70,280.00	TOTAL MEDICAID LIAB	1,041,378.00
		LESS: COB	11,852.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,029,525.27

TOTAL NUMBER OF ADMISSIONS 155

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	569	0	182,080.00	0.00
ROUTINE NURSERY	34	0	10,880.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	603	0	192,960.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	134	0	90,450.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	134	0	90,450.00	0.00
TOTAL ACCOMODATIONS	737	0	283,410.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	576,113.68	0.00	OTHER LAB	2,673.00	0.00
MED/SURG SUPPLY	127,069.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	287,820.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	101.00
CT SCAN	16,938.00	68,979.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	378,327.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,045.00	0.00	MRI SERVICES	3,458.00	0.00
IV THERAPY	4,569.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,442.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,032.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,640.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,826.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,405.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,108.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	505.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,585.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	4,704.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,650.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,458.00	0.00			
AUDIOLOGY	0.00	700.00			
CARDIOLOGY	8,804.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	500.00			

TOTAL ANCILLARY	1,788,151.88	70,280.00
TOTAL ACCOMODATIONS	283,410.00	0.00
TOTAL CHARGES	2,071,561.88	70,280.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,845,449.08	ADJUSTMENTS	50,091.09
COVERED CHARGES	1,543,438.84	CONTRACTUAL ALLOW	1,061,765.09
NON-COVERD CHARGES	302,010.24	TOTAL MEDICAID LIAB	481,673.75
		LESS: COB	2,906.81
		LESS: COPAYMENT	2,304.00
		REIMBURSEMENT	476,462.94
		ALL OTHER	402,962.61
		FEE SCHEDULE-LAB	68,499.16
		INJECTABLE DRUGS	5,001.17

TOTAL NUMBER OF CLAIMS 2,182

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,424.14	85,740.46
MED/SURG SUPPLY	51,804.40	6,624.70
LABORATORY-GENERAL	0.00	11.50
RADIOLOGY-DIAGNOSTIC	90,929.50	2,156.00
CT SCAN	171,153.00	35,216.00
PHYSICAL THERAPY	25,532.00	16,244.00
EKG/ECG	14,013.00	0.00
IV THERAPY	26,905.00	0.00
OPERATING ROOM	116,779.12	39,714.00
LABOR/DELIVERY ROOM	7,821.00	0.00
RESPIRATORY SERVICES	16,526.50	232.50
ANESTHESIA	58,806.00	0.00
GI SERVICES	13,420.50	8,641.00
EMERGENCY ROOM	315,197.50	5,582.00
RECOVERY ROOM	15,688.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,618.00	0.00
OCCUPATIONAL THERAPY	1,999.00	1,996.00
SPEECH PATHOLOGY	458.00	250.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,925.00	820.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	27,762.00	3,368.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,519.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,762.00	0.00
AUDIOLOGY	0.00	100.00
CARDIOLOGY	11,988.00	648.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,500.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,316.89	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,856.00	594.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,235.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	381,593.25	54,031.75
MRI SERVICES	29,449.00	2,560.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	157.20
INJECTABLE DRUGS	50,692.14	34,087.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,543,438.84	302,010.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,543,438.84	302,010.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,759.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,397.05	CONTRACTUAL ALLOW	3,289.58
NON-COVERD CHARGES	362.20	TOTAL MEDICAID LIAB	1,107.47
		LESS: COB	1,104.47
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.50	85.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	235.55	28.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	392.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,602.50	248.50
EKG/ECG	292.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	190.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	339.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,251.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50.00	0.00			

TOTAL ANCILLARY	4,397.05	362.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,397.05	362.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	58,097.03	ADJUSTMENTS	393.35
COVERED CHARGES	52,049.90	CONTRACTUAL ALLOW	43,245.23
NON-COVERD CHARGES	6,047.13	TOTAL MEDICAID LIAB	8,804.67
		LESS: COB	15.00
		LESS: COPAYMENT	351.02
		REIMBURSEMENT	8,438.65

TOTAL NUMBER OF CLAIMS 170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.00	2,234.68
MED/SURG SUPPLY	1,555.55	401.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,000.50	75.50
CT SCAN	2,025.00	675.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	130.00	0.00
IV THERAPY	320.00	0.00
OPERATING ROOM	0.00	1,540.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	279.50	0.00
ANESTHESIA	810.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,075.00	0.00
RECOVERY ROOM	445.50	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,189.50	556.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,162.35	563.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	52,049.90	6,047.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,049.90	6,047.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	307.50	ADJUSTMENTS	0.00
COVERED CHARGES	304.00	CONTRACTUAL ALLOW	83.62
NON-COVERD CHARGES	3.50	TOTAL MEDICAID LIAB	220.38
		LESS: COB	217.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	3.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	304.00	3.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	304.00	3.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,494.10	ADJUSTMENTS	5,264.22
COVERED CHARGES	81,952.95	CONTRACTUAL ALLOW	66,106.29
NON-COVERD CHARGES	541.15	TOTAL MEDICAID LIAB	15,846.66
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	15,801.66

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	366.15
MED/SURG SUPPLY	325.60	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	1,021.50	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	1,065.00	150.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	297.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,010.00	25.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78,233.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	81,952.95	541.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,952.95	541.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA RD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,798,120.44	ADJUSTMENTS	816,169.03
COVERED CHARGES	16,938,259.58	CONTRACTUAL ALLOW	10,290,362.31
NON-COVERD CHARGES	859,860.86	TOTAL MEDICAID LIAB	6,647,897.27
		LESS: COB	42,845.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,605,052.02

TOTAL NUMBER OF ADMISSIONS 799

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,009	0	1,690,110.00	172,375.00
ROUTINE NURSERY	135	0	57,720.00	9,840.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,144	0	1,747,830.00	182,215.00
SPECIAL CARE SERVICES				
CCU	474	0	540,175.40	0.00
ICU	409	0	517,445.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	883	0	1,057,620.40	0.00
TOTAL ACCOMODATIONS	4,027	0	2,805,450.40	182,215.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,845,520.61	1,353.50
MED/SURG SUPPLY	1,912,053.77	7,854.36
LABORATORY-GENERAL	1,885,509.00	5,114.00
RADIOLOGY-DIAGNOSTIC	383,368.00	0.00
CT SCAN	512,093.00	526,669.00
PHYSICAL THERAPY	115,336.00	3,270.00
EKG/ECG	164,260.00	0.00
IV THERAPY	78,190.00	2,793.00
OPERATING ROOM	1,366,888.70	838.00
LABOR/DELIVERY ROOM	51,993.00	0.00
RESPIRATORY SERVICES	931,245.00	13,751.00
ANESTHESIA	943.00	0.00
GI SERVICES	194,098.00	0.00
EMERGENCY ROOM	527,620.00	2,418.00
RECOVERY ROOM	72,976.00	0.00
LABORATORY PATHOLOGIC	26,522.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	7,293.00	179.00
RENAL DIALYSIS	183,849.00	22,587.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	58.00	2,423.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	104,336.00	8,030.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	298,625.00	9,212.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	231,598.00	0.00
AUDIOLOGY	5,635.00	0.00
CARDIOLOGY	678,745.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,662.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	167,107.10	8,855.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	133,194.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	321.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	233,770.00	0.00
PROFESSIONAL FEES	0.00	66.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	19,509.00
DRUG-SPECIFIC/HOME IV	0.00	42,724.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,132,809.18	677,645.86
TOTAL ACCOMODATIONS	2,805,450.40	182,215.00
TOTAL CHARGES	16,938,259.58	859,860.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	102,001.37	ADJUSTMENTS	0.00
COVERED CHARGES	92,724.37	CONTRACTUAL ALLOW	24,868.22
NON-COVERD CHARGES	9,277.00	TOTAL MEDICAID LIAB	67,856.15
		LESS: COB	67,856.15
		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	18	0	10,080.00	900.00
ROUTINE NURSERY	3	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	21	0	11,280.00	900.00
SPECIAL CARE SERVICES				
CCU	3	0	2,280.00	0.00
ICU	1	0	1,265.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	3,545.00	0.00
TOTAL ACCOMODATIONS	25	0	14,825.00	900.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,536.85	0.00
MED/SURG SUPPLY	7,296.02	0.00
LABORATORY-GENERAL	7,764.00	0.00
RADIOLOGY-DIAGNOSTIC	368.00	0.00
CT SCAN	5,685.00	7,664.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	860.00	0.00
IV THERAPY	492.00	0.00
OPERATING ROOM	16,243.00	0.00
LABOR/DELIVERY ROOM	2,073.00	0.00
RESPIRATORY SERVICES	3,230.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,086.00	0.00
RECOVERY ROOM	852.00	0.00
LABORATORY PATHOLOGIC	62.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,111.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,102.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	115.00	0.00
CARDIOLOGY	1,846.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,861.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,316.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	713.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	77,899.37	8,377.00
TOTAL ACCOMODATIONS	14,825.00	900.00
TOTAL CHARGES	92,724.37	9,277.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,995,658.76	ADJUSTMENTS	939,562.64
COVERED CHARGES	13,772,898.78	CONTRACTUAL ALLOW	10,329,314.38
NON-COVERD CHARGES	1,222,759.98	TOTAL MEDICAID LIAB	3,443,584.40
		LESS: COB	1,028.24
		LESS: COPAYMENT	8,418.00
		REIMBURSEMENT	3,434,138.16
		ALL OTHER	2,930,125.83
		FEE SCHEDULE-LAB	333,203.19
		INJECTABLE DRUGS	170,809.14

TOTAL NUMBER OF CLAIMS 7,722

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699,488.12	2,360.15
MED/SURG SUPPLY	604,707.41	66,647.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	635,116.00	29,111.00
CT SCAN	1,920,573.00	182,687.00
PHYSICAL THERAPY	101,816.00	13,854.00
EKG/ECG	190,291.00	172.00
IV THERAPY	207,055.00	38,708.00
OPERATING ROOM	1,307,030.98	143,789.02
LABOR/DELIVERY ROOM	32,279.00	0.00
RESPIRATORY SERVICES	106,818.00	375.00
ANESTHESIA	0.00	4,440.00
GI SERVICES	547,355.00	48,297.00
EMERGENCY ROOM	1,795,696.00	14,908.00
RECOVERY ROOM	216,051.00	810.00
LABORATORY PATHOLOGIC	0.00	124.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,890.00	5,987.00
SPEECH PATHOLOGY	10,365.00	1,775.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	76,927.00	1,624.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	734,181.00	57,481.00
BLOOD	8,430.00	0.00
BLOOD STORAGE & PRO.	54,933.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	375,948.00	94,932.59
AUDIOLOGY	0.00	0.00
CARDIOLOGY	460,280.00	122,412.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,147.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	210,250.50	10,506.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	441,891.00	1,281.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	154.00	52.00
OTHER THERAPEUTIC SVC	504.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,609,115.60	201,930.30
MRI SERVICES	551,280.00	35,111.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	249.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	982.00
INJECTABLE DRUGS	861,326.17	142,137.92
HOME HEALTH SERVICES	0.00	17.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,772,898.78	1,222,759.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,772,898.78	1,222,759.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,680.29	ADJUSTMENTS	0.00
COVERED CHARGES	148,322.39	CONTRACTUAL ALLOW	48,972.58
NON-COVERD CHARGES	35,357.90	TOTAL MEDICAID LIAB	99,349.81
		LESS: COB	99,298.81
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,778.14	0.00
MED/SURG SUPPLY	13,993.45	783.90
LABORATORY-GENERAL	0.00	28.00
RADIOLOGY-DIAGNOSTIC	4,741.00	1,578.00
CT SCAN	8,465.00	6,845.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	860.00	0.00
IV THERAPY	1,590.00	720.00
OPERATING ROOM	32,941.00	9,938.00
LABOR/DELIVERY ROOM	390.00	0.00
RESPIRATORY SERVICES	2,187.00	33.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,524.80	120.00
RECOVERY ROOM	4,098.00	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	162.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,436.00	4,160.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,152.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	756.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,897.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,718.00	3,530.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,477.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,886.00	1,502.00
MRI SERVICES	2,343.00	0.00
PROFESSIONAL FEES	0.00	66.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,401.00	3,401.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	148,322.39	35,357.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,322.39	35,357.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	812,013.42	ADJUSTMENTS	2,476.18
COVERED CHARGES	781,134.92	CONTRACTUAL ALLOW	728,800.96
NON-COVERD CHARGES	30,878.50	TOTAL MEDICAID LIAB	52,333.96
		LESS: COB	0.00
		LESS: COPAYMENT	1,704.05
		REIMBURSEMENT	50,629.91

TOTAL NUMBER OF CLAIMS 936

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,184.34	0.00
MED/SURG SUPPLY	21,086.36	2,322.90
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,647.00	940.00
CT SCAN	85,550.00	14,090.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,912.00	0.00
IV THERAPY	16,858.00	1,080.00
OPERATING ROOM	2,263.00	0.00
LABOR/DELIVERY ROOM	520.00	0.00
RESPIRATORY SERVICES	3,764.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	359,340.00	2,515.00
RECOVERY ROOM	370.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,149.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	29,777.00	3,104.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,555.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,187.00	1,402.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	97,024.00	4,749.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,947.72	675.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	781,134.92	30,878.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	781,134.92	30,878.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,996.54	ADJUSTMENTS	0.00
COVERED CHARGES	8,461.94	CONTRACTUAL ALLOW	5,358.62
NON-COVERD CHARGES	1,534.60	TOTAL MEDICAID LIAB	3,103.32
		LESS: COB	3,094.32
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310.24	229.50	OTHER LAB	957.00	0.00
MED/SURG SUPPLY	17.70	306.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	471.00	287.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,297.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,684.00	22.00
EKG/ECG	172.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,478.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	690.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,461.94	1,534.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,461.94	1,534.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	784,568.99	ADJUSTMENTS	45,488.18
COVERED CHARGES	768,829.09	CONTRACTUAL ALLOW	635,682.21
NON-COVERD CHARGES	15,739.90	TOTAL MEDICAID LIAB	133,146.88
		LESS: COB	0.00
		LESS: COPAYMENT	360.19
		REIMBURSEMENT	132,786.69

TOTAL NUMBER OF CLAIMS 26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,012.11	0.00	OTHER LAB	1,273.00	0.00
MED/SURG SUPPLY	185,540.79	85.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,100.00	608.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,701.00	2,594.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	142.00	FEE SCHEDULE LAB	17,529.90	2,492.10
EKG/ECG	2,408.00	0.00	MRI SERVICES	2,343.00	2,343.00
IV THERAPY	44,899.00	366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	107,997.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,906.00	75.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,039.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,869.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240,153.29	4,770.00
RADIOLOGY THERAPEUTIC	0.00	1,104.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,144.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,853.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,784.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,288.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,802.00	1,160.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,611.00	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/OBSERV. RM	10,576.00	0.00			

TOTAL ANCILLARY	768,829.09	15,739.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	768,829.09	15,739.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,172,429.40	ADJUSTMENTS	89,070.42
COVERED CHARGES	1,148,390.45	CONTRACTUAL ALLOW	540,633.27
NON-COVERD CHARGES	24,038.95	TOTAL MEDICAID LIAB	607,757.18
		LESS: COB	3,832.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	603,924.60

TOTAL NUMBER OF ADMISSIONS 130

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	321	0	130,942.75	22,858.70
ROUTINE NURSERY	50	0	12,350.20	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	371	0	143,292.95	22,858.70
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	10	0	9,353.60	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	10	0	9,353.60	0.00
TOTAL ACCOMODATIONS	381	0	152,646.55	22,858.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,906.30	0.00	OTHER LAB	10,620.50	0.00
MED/SURG SUPPLY	205,006.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	187,872.15	203.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,622.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,681.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,710.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,594.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	40,977.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,620.85	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,726.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,039.25	976.50	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,765.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,984.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,595.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	645.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	420.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,561.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,282.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,097.55	0.00			
AUDIOLOGY	2,787.95	0.00			
CARDIOLOGY	15,678.35	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/OBSERV. RM	548.20	0.00			

TOTAL ANCILLARY	995,743.90	1,180.25
TOTAL ACCOMODATIONS	152,646.55	22,858.70
TOTAL CHARGES	1,148,390.45	24,038.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,966.70	ADJUSTMENTS	0.00
COVERED CHARGES	3,926.10	CONTRACTUAL ALLOW	1,371.13
NON-COVERD CHARGES	40.60	TOTAL MEDICAID LIAB	2,554.97
		LESS: COB	2,554.97
		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	2	0	816.00	40.60
ROUTINE NURSERY	2	0	497.80	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,313.80	40.60
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,313.80	40.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	861.45	0.00	OTHER LAB	432.40	0.00
MED/SURG SUPPLY	274.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	915.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	127.55	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,612.30	0.00
TOTAL ACCOMODATIONS	1,313.80	40.60
TOTAL CHARGES	3,926.10	40.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,505,100.16	ADJUSTMENTS	51,119.28
COVERED CHARGES	1,348,319.18	CONTRACTUAL ALLOW	1,084,953.18
NON-COVERD CHARGES	156,780.98	TOTAL MEDICAID LIAB	263,366.00
		LESS: COB	706.98
		LESS: COPAYMENT	1,293.00
		REIMBURSEMENT	261,366.02
		ALL OTHER	220,082.00
		FEE SCHEDULE-LAB	41,176.47
		INJECTABLE DRUGS	107.55

TOTAL NUMBER OF CLAIMS 1,223

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,109.85	20,204.45
MED/SURG SUPPLY	63,445.66	3,434.55
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	107,869.25	461.85
CT SCAN	117,991.90	12,122.05
PHYSICAL THERAPY	2,979.00	90.00
EKG/ECG	12,110.90	772.20
IV THERAPY	48,401.70	1,313.80
OPERATING ROOM	54,018.08	11,633.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,198.75	0.00
ANESTHESIA	30,629.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	342,359.30	2,925.55
RECOVERY ROOM	15,580.35	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	60,814.95	2,062.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,443.00	632.65
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,791.00	125.15
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,112.35	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,914.55	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,828.00	4,147.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	22,964.80	2,299.10
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	361,516.99	86,466.75
MRI SERVICES	20,615.85	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	623.65	8,090.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,348,319.18	156,780.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,348,319.18	156,780.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,785.95	ADJUSTMENTS	0.00
COVERED CHARGES	12,668.35	CONTRACTUAL ALLOW	2,758.18
NON-COVERD CHARGES	1,117.60	TOTAL MEDICAID LIAB	9,910.17
		LESS: COB	9,907.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	506.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	837.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,972.50	1,117.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,662.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,416.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,668.35	1,117.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,668.35	1,117.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	157,849.10	ADJUSTMENTS	2,097.66
COVERED CHARGES	149,677.60	CONTRACTUAL ALLOW	138,920.67
NON-COVERD CHARGES	8,171.50	TOTAL MEDICAID LIAB	10,756.93
		LESS: COB	0.00
		LESS: COPAYMENT	342.01
		REIMBURSEMENT	10,414.92

TOTAL NUMBER OF CLAIMS 199

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,287.95	912.10	OTHER LAB	4,324.00	0.00
MED/SURG SUPPLY	3,386.90	75.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,954.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,460.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,080.40	5,389.30
EKG/ECG	1,200.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,663.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,736.40	191.05	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	340.75	357.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,421.85	1,246.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	568.50	0.00			

TOTAL ANCILLARY	149,677.60	8,171.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	149,677.60	8,171.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,268.15	ADJUSTMENTS	0.00
COVERED CHARGES	1,250.20	CONTRACTUAL ALLOW	232.05
NON-COVERD CHARGES	17.95	TOTAL MEDICAID LIAB	1,018.15
		LESS: COB	1,018.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	582.25	17.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	660.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,250.20	17.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,250.20	17.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDIAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,983,674.12	ADJUSTMENTS	216,495.83
COVERED CHARGES	1,945,860.32	CONTRACTUAL ALLOW	938,424.33
NON-COVERD CHARGES	37,813.80	TOTAL MEDICAID LIAB	1,007,435.99
		LESS: COB	5,957.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,001,478.31

TOTAL NUMBER OF ADMISSIONS 222

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	704	3	355,520.00	31,935.00
ROUTINE NURSERY	89	0	38,720.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	793	4	394,240.00	31,935.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	54	0	54,810.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	54	0	54,810.00	0.00
TOTAL ACCOMODATIONS	847	4	449,050.00	31,935.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	412,824.50	0.00	OTHER LAB	7,786.00	0.00
MED/SURG SUPPLY	302,530.35	189.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	287,274.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,982.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	88,578.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,281.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,559.00	0.00	MRI SERVICES	24,115.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,811.02	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,271.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,448.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,246.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,447.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,842.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,671.00	0.00	INJECTABLE DRUGS	9,507.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	336.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,288.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	577.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	342.80
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	4,464.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,188.00	2,998.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,627.00	0.00			
AUDIOLOGY	2,208.00	0.00			
CARDIOLOGY	9,448.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,500.00	2,349.00			

TOTAL ANCILLARY	1,496,810.32	5,878.80
TOTAL ACCOMODATIONS	449,050.00	31,935.00
TOTAL CHARGES	1,945,860.32	37,813.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2210361007337	12/12/10 - 12/14/10	01/17/11	0.00	328.00	0.00	0.00	0.00
71	2211206010800	03/18/11 - 03/20/11	08/01/11	0.00	14.80	0.00	0.00	0.00
TOTAL				0.00	342.80	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,500,946.78	ADJUSTMENTS	160,996.36
COVERED CHARGES	2,223,661.56	CONTRACTUAL ALLOW	1,576,952.66
NON-COVERD CHARGES	277,285.22	TOTAL MEDICAID LIAB	646,708.90
		LESS: COB	3,179.35
		LESS: COPAYMENT	4,902.00
		REIMBURSEMENT	638,627.55
		ALL OTHER	530,192.47
		FEE SCHEDULE-LAB	108,115.22
		INJECTABLE DRUGS	319.86

TOTAL NUMBER OF CLAIMS 3,341

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,167.65	4,241.65
MED/SURG SUPPLY	126,254.25	3,462.00
LABORATORY-GENERAL	0.00	2,775.00
RADIOLOGY-DIAGNOSTIC	187,470.00	4,930.00
CT SCAN	251,701.00	29,170.00
PHYSICAL THERAPY	25,349.00	14,913.00
EKG/ECG	43,776.00	471.00
IV THERAPY	0.00	0.00
OPERATING ROOM	182,372.26	39,138.74
LABOR/DELIVERY ROOM	4,230.00	0.00
RESPIRATORY SERVICES	19,371.00	1,782.00
ANESTHESIA	10,119.10	232.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	265,139.00	1,750.00
RECOVERY ROOM	13,686.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	210.00	1,566.00
SPEECH PATHOLOGY	0.00	681.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	58,219.00	1,930.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,904.00	1,907.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,031.00	0.00
AUDIOLOGY	68.00	0.00
CARDIOLOGY	23,650.00	0.00
AMBULATORY SURGERY	42.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,988.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	67,853.00	9,847.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,595.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	685,251.00	141,432.00
MRI SERVICES	93,170.00	8,367.00
PROFESSIONAL FEES	0.00	359.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,045.30	6,984.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	286.00

TOTAL ANCILLARY	2,223,661.56	276,225.22
TOTAL ACCOMODATIONS	0.00	1,060.00
TOTAL CHARGES	2,223,661.56	277,285.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	4010288087283	09/17/10 - 09/17/10	10/25/10	0.00	168.00	0.00	0.00	0.00
763	4010288087283	09/17/10 - 09/17/10	10/25/10	0.00	118.00	0.00	0.00	0.00
TOTAL				0.00	286.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,277.80	ADJUSTMENTS	0.00
COVERED CHARGES	15,770.90	CONTRACTUAL ALLOW	7,679.74
NON-COVERD CHARGES	1,506.90	TOTAL MEDICAID LIAB	8,091.16
		LESS: COB	8,073.16
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	384.75	0.00
MED/SURG SUPPLY	639.15	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,387.00	221.00
CT SCAN	1,818.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,205.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	80.00	0.00
ANESTHESIA	47.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,785.00	0.00
RECOVERY ROOM	232.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	610.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,853.00	1,043.00
MRI SERVICES	1,730.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	242.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,770.90	1,506.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,770.90	1,506.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,173.20	ADJUSTMENTS	2,251.04
COVERED CHARGES	58,298.80	CONTRACTUAL ALLOW	47,463.95
NON-COVERD CHARGES	874.40	TOTAL MEDICAID LIAB	10,834.85
		LESS: COB	0.00
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	10,402.85

TOTAL NUMBER OF CLAIMS 212

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,437.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	956.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,092.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,869.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,878.00	535.00
EKG/ECG	498.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	176.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,913.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.00	339.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,350.00	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	58,298.80	874.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,298.80	874.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,322.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,322.00	CONTRACTUAL ALLOW	345.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	976.64
		LESS: COB	976.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	899.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	423.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,322.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,322.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	100,269,948.02	ADJUSTMENTS	4,010,230.97
COVERED CHARGES	96,230,740.80	CONTRACTUAL ALLOW	66,171,968.25
NON-COVERD CHARGES	4,039,207.22	TOTAL MEDICAID LIAB	30,058,772.55
		LESS: COB	129,318.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,929,453.58

TOTAL NUMBER OF ADMISSIONS 2,729

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,043	329	7,432,765.00	2,573,018.00
ROUTINE NURSERY	1,389	104	2,518,003.00	216,210.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	2.00	41.00
TOTAL ROUTINE	11,432	435	9,950,770.00	2,789,269.00
SPECIAL CARE SERVICES				
CCU	234	2	634,140.00	5,420.00
ICU	2,699	66	4,833,109.00	125,253.00
NICU	919	13	2,708,381.00	38,311.00
PED ICU	613	1	2,171,859.00	3,543.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	482	21	1,306,433.00	56,910.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,947	103	11,653,922.00	229,437.00
TOTAL ACCOMODATIONS	16,379	538	21,604,692.00	3,018,706.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,094,105.12	14,862.30
MED/SURG SUPPLY	12,709,499.38	111,040.57
LABORATORY-GENERAL	8,656,078.54	44,891.38
RADIOLOGY-DIAGNOSTIC	2,246,075.00	4,168.00
CT SCAN	4,118,804.00	69,563.00
PHYSICAL THERAPY	846,548.00	5,526.00
EKG/ECG	282,562.00	0.00
IV THERAPY	986,355.00	21,033.00
OPERATING ROOM	9,589,305.10	43,913.00
LABOR/DELIVERY ROOM	763,202.00	708.00
RESPIRATORY SERVICES	4,496,788.32	9,970.84
ANESTHESIA	3,498,642.15	9,195.85
GI SERVICES	200,343.00	0.00
EMERGENCY ROOM	2,366,555.00	240.00
RECOVERY ROOM	1,413,842.00	8,981.00
LABORATORY PATHOLOGIC	228,567.80	0.00
RADIOLOGY THERAPEUTIC	176,945.00	0.00
OCCUPATIONAL THERAPY	577,430.00	4,698.00
SPEECH PATHOLOGY	239,098.00	0.00
RENAL DIALYSIS	274,147.00	86,376.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,325.00	6,153.00
PSYCHIATRIC SERVICES	2,238.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	634,352.00	9,366.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	750,926.40	121,890.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	216,146.00	80,876.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,013,956.00	1,132.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	148,580.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	25,187.14	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	478,502.94	1,845.43
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	34.00	0.00
OTHER THERAPEUTIC SVC	7,071.00	55,823.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,164,245.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	19,698.00	147.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	179,381.15
INJECTABLE DRUGS	4,398,894.91	6,216.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	23.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	102,888.00
NO CC/INVALID REV CODE	0.00	19,593.00

TOTAL ANCILLARY	74,626,048.80	1,020,501.22
TOTAL ACCOMODATIONS	21,604,692.00	3,018,706.00
TOTAL CHARGES	96,230,740.80	4,039,207.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2211276008883	08/08/11 - 09/05/11	10/10/11	0.00	19,593.00	0.00	0.00	0.00
TOTAL				0.00	19,593.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	438,899.15	ADJUSTMENTS	0.00
COVERED CHARGES	425,795.15	CONTRACTUAL ALLOW	227,036.81
NON-COVERD CHARGES	13,104.00	TOTAL MEDICAID LIAB	198,758.34
		LESS: COB	198,758.34
		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	30	0	22,230.00	13,009.00
ROUTINE NURSERY	41	0	106,723.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	71	0	128,953.00	13,009.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	18	0	48,115.00	0.00
NICU	2	0	5,894.00	0.00
PED ICU	3	0	10,629.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	23	0	64,638.00	0.00
TOTAL ACCOMODATIONS	94	0	193,591.00	13,009.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,032.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	58,087.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,458.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,532.00	0.00	OTHER THERAPEUTIC SVC	0.00	95.00
CT SCAN	1,992.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	348.00	0.00	MRI SERVICES	5,344.00	0.00
IV THERAPY	1,722.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,451.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,175.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,995.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,235.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,613.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,823.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,139.00	0.00	INJECTABLE DRUGS	26,714.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,838.60	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	904.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	232,204.15	95.00
TOTAL ACCOMODATIONS	193,591.00	13,009.00
TOTAL CHARGES	425,795.15	13,104.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,988,806.26	ADJUSTMENTS	217,922.95
COVERED CHARGES	25,062,266.22	CONTRACTUAL ALLOW	19,605,634.45
NON-COVERD CHARGES	3,926,540.04	TOTAL MEDICAID LIAB	5,456,631.77
		LESS: COB	22,284.76
		LESS: COPAYMENT	14,145.86
		REIMBURSEMENT	5,420,201.15
		ALL OTHER	4,650,274.86
		FEE SCHEDULE-LAB	363,761.96
		INJECTABLE DRUGS	406,164.33

TOTAL NUMBER OF CLAIMS 13,580

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	594,122.11	2,097.85
MED/SURG SUPPLY	1,968,021.82	58,146.75
LABORATORY-GENERAL	0.00	222.00
RADIOLOGY-DIAGNOSTIC	1,266,085.00	71,380.00
CT SCAN	2,679,723.00	478,619.00
PHYSICAL THERAPY	196,811.00	66,362.00
EKG/ECG	193,866.00	696.00
IV THERAPY	710,806.00	34,945.00
OPERATING ROOM	2,346,193.02	1,268,513.96
LABOR/DELIVERY ROOM	134,948.00	0.00
RESPIRATORY SERVICES	130,407.00	35,899.00
ANESTHESIA	1,476,786.25	0.00
GI SERVICES	216,437.83	42,965.17
EMERGENCY ROOM	3,576,095.00	10,649.00
RECOVERY ROOM	933,563.00	371.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	826,299.00	46,910.00
OCCUPATIONAL THERAPY	30,451.00	44,059.00
SPEECH PATHOLOGY	14,462.00	15,076.00
RENAL DIALYSIS	0.00	9,114.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	282,125.00	3,804.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	27,680.00	0.00
OTHER IMAGING SERVICE	876,736.00	73,194.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,599.66	95,580.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	328,093.00	225,200.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	170,908.00	133,963.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,760.00	1,272.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	346,621.26	8,192.33

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	594,924.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	102.00
OTHER THERAPEUTIC SVC	864.00	15,062.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,547,750.46	656,842.39
MRI SERVICES	1,093,129.00	161,237.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	1,323.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,839.50
INJECTABLE DRUGS	1,478,998.81	342,510.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	45.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	12,348.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	25,062,266.22	3,926,540.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,062,266.22	3,926,540.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	370,569.91	ADJUSTMENTS	0.00
COVERED CHARGES	229,169.58	CONTRACTUAL ALLOW	127,690.93
NON-COVERD CHARGES	141,400.33	TOTAL MEDICAID LIAB	101,478.65
		LESS: COB	101,406.68
		LESS: COPAYMENT	71.97
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	135

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,109.35	1,356.50
MED/SURG SUPPLY	19,781.63	2,841.75
LABORATORY-GENERAL	0.00	54.10
RADIOLOGY-DIAGNOSTIC	11,135.00	1,576.00
CT SCAN	12,408.00	21,014.00
PHYSICAL THERAPY	0.00	7,596.00
EKG/ECG	2,640.00	174.00
IV THERAPY	6,346.00	444.00
OPERATING ROOM	16,081.00	10,083.00
LABOR/DELIVERY ROOM	534.00	0.00
RESPIRATORY SERVICES	1,810.00	0.00
ANESTHESIA	9,820.00	789.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,232.00	1,351.00
RECOVERY ROOM	6,193.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,673.00	1,120.00
OCCUPATIONAL THERAPY	1,083.00	5,819.00
SPEECH PATHOLOGY	250.00	3,076.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,687.00	896.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,918.00	931.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,862.57	20,463.51
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	960.00	447.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	904.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,796.89	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,429.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	432.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,482.69	12,478.62
MRI SERVICES	30,666.00	37,874.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,367.45	10,499.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	84.25

TOTAL ANCILLARY	229,169.58	141,400.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,169.58	141,400.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2712	5912150000528	12/23/11 - 12/23/11	06/04/12	0.00	84.25	0.00	1,642.68	0.00
TOTAL				0.00	84.25	0.00	1,642.68	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	638,382.19	ADJUSTMENTS	326.64
COVERED CHARGES	611,959.08	CONTRACTUAL ALLOW	564,466.02
NON-COVERD CHARGES	26,423.11	TOTAL MEDICAID LIAB	47,493.06
		LESS: COB	0.00
		LESS: COPAYMENT	1,026.01
		REIMBURSEMENT	46,467.05

TOTAL NUMBER OF CLAIMS 849

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,844.35	0.00
MED/SURG SUPPLY	25,030.75	225.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,985.00	240.00
CT SCAN	21,029.00	1,992.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,872.00	0.00
IV THERAPY	19,396.00	666.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,616.00	0.00
RESPIRATORY SERVICES	1,484.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	376,710.00	260.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	212.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,919.00	681.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,533.99	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,513.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	81,114.44	19,149.31
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,699.55	3,209.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	611,959.08	26,423.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	611,959.08	26,423.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,232.71	ADJUSTMENTS	0.00
COVERED CHARGES	5,870.22	CONTRACTUAL ALLOW	4,945.59
NON-COVERD CHARGES	362.49	TOTAL MEDICAID LIAB	924.63
		LESS: COB	915.63
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	310.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	421.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	474.87	282.24
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	640.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.30	80.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,870.22	362.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,870.22	362.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,464,050.34	ADJUSTMENTS	87,674.24
COVERED CHARGES	6,575,796.02	CONTRACTUAL ALLOW	5,441,750.36
NON-COVERD CHARGES	888,254.32	TOTAL MEDICAID LIAB	1,134,045.66
		LESS: COB	0.00
		LESS: COPAYMENT	1,935.04
		REIMBURSEMENT	1,132,110.62

TOTAL NUMBER OF CLAIMS 202

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,105.70	0.00
MED/SURG SUPPLY	2,570,363.22	30,393.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,675.00	45,572.00
CT SCAN	51,611.00	9,161.00
PHYSICAL THERAPY	0.00	3,276.00
EKG/ECG	4,350.00	0.00
IV THERAPY	49,711.00	148.00
OPERATING ROOM	665,776.78	494,397.47
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	850.00	0.00
ANESTHESIA	280,466.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,841.00	0.00
RECOVERY ROOM	114,859.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	704,200.00	41,254.00
OCCUPATIONAL THERAPY	722.00	75.00
SPEECH PATHOLOGY	0.00	576.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,787.00	411.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,227.00	529.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	16,120.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,512.00	1,834.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	174,040.00	26,047.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,377.96	1.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,896.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	204.00	8,327.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	70,045.66	23,929.06
MRI SERVICES	11,904.00	3,297.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	588.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,648,271.70	182,314.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	4.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,575,796.02	888,254.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,575,796.02	888,254.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,561.50	ADJUSTMENTS	0.00
COVERED CHARGES	70,189.50	CONTRACTUAL ALLOW	39,049.33
NON-COVERD CHARGES	4,372.00	TOTAL MEDICAID LIAB	31,140.17
		LESS: COB	31,137.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66,047.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	76.41	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,372.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,874.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,742.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	70,189.50	4,372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,189.50	4,372.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,047.78	ADJUSTMENTS	0.00
COVERED CHARGES	78,184.78	CONTRACTUAL ALLOW	41,844.34
NON-COVERD CHARGES	7,863.00	TOTAL MEDICAID LIAB	36,340.44
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,340.44

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15	12	7,800.00	6,960.00
ROUTINE NURSERY	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	15	12	7,800.00	6,960.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	12	7,800.00	6,960.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,857.50	0.00	OTHER LAB	376.00	0.00
MED/SURG SUPPLY	6,391.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,601.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,960.00	0.00	OTHER THERAPEUTIC SVC	0.00	903.00
CT SCAN	5,254.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,032.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	63.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,946.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,064.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,023.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,407.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,523.28	0.00			

TOTAL ANCILLARY	70,384.78	903.00
TOTAL ACCOMODATIONS	7,800.00	6,960.00
TOTAL CHARGES	78,184.78	7,863.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	963,650.09	ADJUSTMENTS	29,981.20
COVERED CHARGES	812,990.92	CONTRACTUAL ALLOW	521,139.61
NON-COVERD CHARGES	150,659.17	TOTAL MEDICAID LIAB	291,851.31
		LESS: COB	1,316.59
		LESS: COPAYMENT	906.00
		REIMBURSEMENT	289,628.72
		ALL OTHER	268,665.75
		FEE SCHEDULE-LAB	15,406.52
		INJECTABLE DRUGS	5,556.45

TOTAL NUMBER OF CLAIMS 834

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,852.65	4,920.95
MED/SURG SUPPLY	31,112.25	1,851.00
LABORATORY-GENERAL	0.00	4,699.60
RADIOLOGY-DIAGNOSTIC	72,172.00	1,286.00
CT SCAN	32,266.00	77,459.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	34,290.00	1,270.00
IV THERAPY	5,919.00	0.00
OPERATING ROOM	11,553.00	2,195.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,136.00	232.00
ANESTHESIA	0.00	0.00
GI SERVICES	59,883.00	4,852.00
EMERGENCY ROOM	242,148.39	1,321.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	198.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,167.00	1,282.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,128.00	3,368.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,546.00	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/OBSERV. RM	16,157.91	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,315.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	8,016.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	129,440.12	29,473.12
MRI SERVICES	77,809.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,095.60	1,258.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	393.00

TOTAL ANCILLARY	812,990.92	144,075.17
TOTAL ACCOMODATIONS	0.00	6,584.00
TOTAL CHARGES	812,990.92	150,659.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8004	2211145001293	05/20/11 - 05/20/11	05/30/11	0.00	95.00	0.00	0.00	0.00
8388	5911228001243	07/26/11 - 07/27/11	08/22/11	0.00	298.00	0.00	0.00	0.00
TOTAL				0.00	393.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,952.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,606.00	CONTRACTUAL ALLOW	1,461.14
NON-COVERD CHARGES	1,346.00	TOTAL MEDICAID LIAB	2,144.86
		LESS: COB	2,144.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,008.00	169.00
EKG/ECG	508.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,588.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,606.00	1,346.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,606.00	1,346.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	126,978.65	ADJUSTMENTS	143.99
COVERED CHARGES	114,026.65	CONTRACTUAL ALLOW	104,176.65
NON-COVERD CHARGES	12,952.00	TOTAL MEDICAID LIAB	9,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	378.03
		REIMBURSEMENT	9,471.97

TOTAL NUMBER OF CLAIMS 197

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,816.05	14.00
MED/SURG SUPPLY	1,019.00	160.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,980.00	0.00
CT SCAN	2,278.00	8,934.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,048.00	0.00
IV THERAPY	606.00	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	77,916.00	200.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	462.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	376.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,056.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,680.00	2,027.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,307.60	99.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	114,026.65	12,952.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	114,026.65	12,952.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	235.00	ADJUSTMENTS	0.00
COVERED CHARGES	235.00	CONTRACTUAL ALLOW	146.88
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	88.12
		LESS: COB	88.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	217.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	235.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	235.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WARM SPRINGS MEDICAL CENTER
PO BOX 8
WARM SPRINGS,GA 31830-0008

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,082,746.30	ADJUSTMENTS	23,661.11
COVERED CHARGES	1,081,749.30	CONTRACTUAL ALLOW	666,785.12
NON-COVERD CHARGES	997.00	TOTAL MEDICAID LIAB	414,964.18
		LESS: COB	539.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	414,424.98

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	354	0	135,135.00	0.00
ROUTINE NURSERY	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	354	0	135,135.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	354	0	135,135.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	348,838.25	0.00
MED/SURG SUPPLY	134,341.85	69.00
LABORATORY-GENERAL	115,122.30	0.00
RADIOLOGY-DIAGNOSTIC	19,453.60	0.00
CT SCAN	128,203.00	0.00
PHYSICAL THERAPY	6,534.00	0.00
EKG/ECG	7,957.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,670.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	62,332.00	0.00
ANESTHESIA	1,818.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	47,643.00	0.00
RECOVERY ROOM	1,605.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	940.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,260.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,268.00	928.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,044.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,256.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,777.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	629.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	9,922.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	946,614.30	997.00
TOTAL ACCOMODATIONS	135,135.00	0.00
TOTAL CHARGES	1,081,749.30	997.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	886.00	ADJUSTMENTS	0.00
COVERED CHARGES	886.00	CONTRACTUAL ALLOW	132.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	753.10
		LESS: COB	753.10
		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	1	0	385.00	0.00
ROUTINE NURSERY	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	385.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	385.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	181.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	320.00	0.00			

TOTAL ANCILLARY	501.00	0.00
TOTAL ACCOMODATIONS	385.00	0.00
TOTAL CHARGES	886.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	905,299.33	ADJUSTMENTS	27,539.67
COVERED CHARGES	812,136.33	CONTRACTUAL ALLOW	520,310.61
NON-COVERD CHARGES	93,163.00	TOTAL MEDICAID LIAB	291,825.72
		LESS: COB	1,098.21
		LESS: COPAYMENT	1,539.00
		REIMBURSEMENT	289,188.51
		ALL OTHER	260,455.85
		FEE SCHEDULE-LAB	28,732.66
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,332

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,777.03	22.00
MED/SURG SUPPLY	42,717.55	69.00
LABORATORY-GENERAL	0.00	903.00
RADIOLOGY-DIAGNOSTIC	60,720.30	2,000.00
CT SCAN	148,320.00	36,899.00
PHYSICAL THERAPY	1,122.00	209.00
EKG/ECG	8,157.00	1,417.00
IV THERAPY	0.00	0.00
OPERATING ROOM	22,759.00	2,722.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,714.00	531.00
ANESTHESIA	4,655.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	145,431.00	0.00
RECOVERY ROOM	3,937.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	5,239.00	507.00
RENAL DIALYSIS	0.00	79.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	316.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	37,838.00	746.00
BLOOD	1,528.00	0.00
BLOOD STORAGE & PRO.	952.00	464.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,149.00	760.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,656.00	252.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,256.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,822.65	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	25,712.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	178,997.80	44,419.00
MRI SERVICES	19,360.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	394.00

TOTAL ANCILLARY	812,136.33	92,393.00
TOTAL ACCOMODATIONS	0.00	770.00
TOTAL CHARGES	812,136.33	93,163.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
45	2212151003442	05/14/11 - 05/15/11	06/04/12	0.00	394.00	0.00	0.00	0.00
TOTAL				0.00	394.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,276.15	ADJUSTMENTS	0.00
COVERED CHARGES	20,144.15	CONTRACTUAL ALLOW	7,032.15
NON-COVERD CHARGES	3,132.00	TOTAL MEDICAID LIAB	13,112.00
		LESS: COB	13,088.17
		LESS: COPAYMENT	23.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,796.15	0.00	OTHER LAB	2,411.00	666.00
MED/SURG SUPPLY	2,039.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	620.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	209.00	FEE SCHEDULE LAB	4,363.00	856.00
EKG/ECG	545.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	887.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,202.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	212.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,720.00	0.00			

TOTAL ANCILLARY	20,144.15	3,132.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,144.15	3,132.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,240.95	ADJUSTMENTS	529.00
COVERED CHARGES	58,363.95	CONTRACTUAL ALLOW	51,989.95
NON-COVERD CHARGES	877.00	TOTAL MEDICAID LIAB	6,374.00
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	6,089.00

TOTAL NUMBER OF CLAIMS 131

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,686.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,605.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,099.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,769.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,007.00	492.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,896.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	385.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116.00	0.00			

TOTAL ANCILLARY	58,363.95	877.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,363.95	877.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,426.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,426.40	CONTRACTUAL ALLOW	1,069.46
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	356.94
		LESS: COB	353.94
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	96.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	283.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,426.40	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,426.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,791.60	ADJUSTMENTS	0.00
COVERED CHARGES	12,125.60	CONTRACTUAL ALLOW	7,817.38
NON-COVERD CHARGES	666.00	TOTAL MEDICAID LIAB	4,308.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,308.22

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,509.60	0.00
MED/SURG SUPPLY	724.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	145.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	109.00	436.00
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	2,048.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	590.00	230.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,125.60	666.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,125.60	666.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL
PO BOX 7
COLQUITT,GA 39837-0007

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	274,042.34	ADJUSTMENTS	0.00
COVERED CHARGES	274,042.34	CONTRACTUAL ALLOW	155,756.62
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	118,285.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	118,285.72

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	102	0	66,300.00	0.00
ROUTINE NURSERY	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	102	0	66,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	102	0	66,300.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,211.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,246.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,374.19	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,604.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,843.44	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,717.01	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,158.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,258.47	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,553.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,121.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,625.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,500.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,101.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	565.95	0.00	INJECTABLE DRUGS	42,386.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,339.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,389.60	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/OBSERV. RM	744.70	0.00			

TOTAL ANCILLARY	207,742.34	0.00
TOTAL ACCOMODATIONS	66,300.00	0.00
TOTAL CHARGES	274,042.34	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	951,048.37	ADJUSTMENTS	21,184.60
COVERED CHARGES	781,526.68	CONTRACTUAL ALLOW	385,512.34
NON-COVERD CHARGES	169,521.69	TOTAL MEDICAID LIAB	396,014.34
		LESS: COB	0.00
		LESS: COPAYMENT	1,257.00
		REIMBURSEMENT	394,757.34
		ALL OTHER	361,251.74
		FEE SCHEDULE-LAB	29,024.48
		INJECTABLE DRUGS	4,481.12

TOTAL NUMBER OF CLAIMS 947

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,746.27	141.48
MED/SURG SUPPLY	18,769.27	0.00
LABORATORY-GENERAL	0.00	57.12
RADIOLOGY-DIAGNOSTIC	60,530.65	836.00
CT SCAN	85,971.78	77,713.16
PHYSICAL THERAPY	7,921.73	4,355.87
EKG/ECG	17,391.00	154.50
IV THERAPY	28,981.48	2,289.26
OPERATING ROOM	51,305.00	16,401.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,362.50	52.50
ANESTHESIA	9,471.97	1,903.44
GI SERVICES	0.00	0.00
EMERGENCY ROOM	141,379.46	604.75
RECOVERY ROOM	20,016.10	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	202.91
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	23,343.26	2,272.41
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,472.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	24,991.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,444.18	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,042.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	198,347.72	52,916.65
MRI SERVICES	4,875.88	0.00
PROFESSIONAL FEES	0.00	604.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,163.28	9,016.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	781,526.68	169,521.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	781,526.68	169,521.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,212.50	ADJUSTMENTS	0.00
COVERED CHARGES	2,471.38	CONTRACTUAL ALLOW	-3,414.43
NON-COVERD CHARGES	4,741.12	TOTAL MEDICAID LIAB	5,885.81
		LESS: COB	5,882.81
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	662.55	1,622.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,880.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	798.00	115.61
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	281.52	122.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	494.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	209.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,471.38	4,741.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,471.38	4,741.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	100,220.05	ADJUSTMENTS	287.99
COVERED CHARGES	88,357.11	CONTRACTUAL ALLOW	79,307.11
NON-COVERD CHARGES	11,862.94	TOTAL MEDICAID LIAB	9,050.00
		LESS: COB	0.00
		LESS: COPAYMENT	318.01
		REIMBURSEMENT	8,731.99

TOTAL NUMBER OF CLAIMS 181

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	838.92	215.27
MED/SURG SUPPLY	1,354.22	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,743.46	0.00
CT SCAN	1,541.00	2,953.60
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,995.00	0.00
IV THERAPY	1,871.33	339.20
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	830.75	68.25
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	43,749.52	81.20
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 SERVICE	1,277.20	1,552.87
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	741.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,396.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,320.85	4,187.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,438.80	1,723.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	88,357.11	11,862.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,357.11	11,862.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,537.83	ADJUSTMENTS	0.00
COVERED CHARGES	1,522.18	CONTRACTUAL ALLOW	1,162.74
NON-COVERD CHARGES	15.65	TOTAL MEDICAID LIAB	359.44
		LESS: COB	356.44
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	674.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	289.80	15.65
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	427.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	65.88	0.00			

TOTAL ANCILLARY	1,522.18	15.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,522.18	15.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,815.97	ADJUSTMENTS	0.00
COVERED CHARGES	40,163.74	CONTRACTUAL ALLOW	22,666.46
NON-COVERD CHARGES	11,652.23	TOTAL MEDICAID LIAB	17,497.28
		LESS: COB	0.00
		LESS: COPAYMENT	16.75
		REIMBURSEMENT	17,480.53

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,535.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,974.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	802.41	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,187.01	79.40
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,773.41	8,361.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,996.86	1,313.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,410.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,286.40	870.65
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	225.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,163.74	11,652.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,163.74	11,652.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC
1201 SILOAM RD
GREENSBORO,GA 30642-2811

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	295,094.52	ADJUSTMENTS	0.00
COVERED CHARGES	293,041.52	CONTRACTUAL ALLOW	145,758.87
NON-COVERD CHARGES	2,053.00	TOTAL MEDICAID LIAB	147,282.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	147,282.65

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	43,370.00	2,053.00
ROUTINE NURSERY	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	83	0	43,370.00	2,053.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	83	0	43,370.00	2,053.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,257.52	0.00	OTHER LAB	1,249.00	0.00
MED/SURG SUPPLY	21,759.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,382.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,906.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,980.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,776.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,474.00	0.00	MRI SERVICES	3,779.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,529.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,721.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,197.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,499.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	661.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,835.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	667.00	0.00			

TOTAL ANCILLARY	249,671.52	0.00
TOTAL ACCOMODATIONS	43,370.00	2,053.00
TOTAL CHARGES	293,041.52	2,053.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,158,057.24	ADJUSTMENTS	94,579.00
COVERED CHARGES	1,834,302.44	CONTRACTUAL ALLOW	1,286,103.07
NON-COVERD CHARGES	323,754.80	TOTAL MEDICAID LIAB	548,199.37
		LESS: COB	1,365.05
		LESS: COPAYMENT	2,520.00
		REIMBURSEMENT	544,314.32
		ALL OTHER	490,021.69
		FEE SCHEDULE-LAB	51,874.35
		INJECTABLE DRUGS	2,418.28

TOTAL NUMBER OF CLAIMS 2,092

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261,472.64	32,099.00
MED/SURG SUPPLY	31,160.00	0.00
LABORATORY-GENERAL	0.00	343.00
RADIOLOGY-DIAGNOSTIC	120,079.00	1,288.00
CT SCAN	231,939.00	126,765.00
PHYSICAL THERAPY	62,271.00	10,726.00
EKG/ECG	20,115.00	165.00
IV THERAPY	58,519.00	3,144.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,603.00	8,128.00
ANESTHESIA	0.00	642.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	404,704.00	4,757.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,139.00	0.00
SPEECH PATHOLOGY	5,226.00	810.00
RENAL DIALYSIS	0.00	31.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	68.00	128.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	41,370.00	1,465.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,732.00	3,366.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,450.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	54,056.00	2,161.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,119.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	415,213.00	73,921.60
MRI SERVICES	35,553.00	6,222.00
PROFESSIONAL FEES	0.00	180.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	49,513.80	47,413.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,834,302.44	323,754.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,834,302.44	323,754.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,766.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,564.00	CONTRACTUAL ALLOW	120.29
NON-COVERD CHARGES	2,202.00	TOTAL MEDICAID LIAB	5,443.71
		LESS: COB	5,441.56
		LESS: COPAYMENT	2.15
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56.00	0.00
MED/SURG SUPPLY	107.00	0.00
LABORATORY-GENERAL	0.00	38.00
RADIOLOGY-DIAGNOSTIC	223.00	0.00
CT SCAN	0.00	1,219.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	31.00	103.00
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	1,939.00	29.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	596.00	298.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,565.00	158.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	357.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,564.00	2,202.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,564.00	2,202.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	105,265.00	ADJUSTMENTS	325.07
COVERED CHARGES	96,023.00	CONTRACTUAL ALLOW	86,579.92
NON-COVERD CHARGES	9,242.00	TOTAL MEDICAID LIAB	9,443.08
		LESS: COB	0.00
		LESS: COPAYMENT	393.02
		REIMBURSEMENT	9,050.06

TOTAL NUMBER OF CLAIMS 190

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,183.00	240.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,652.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,587.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,054.00	3,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	271.00	FEE SCHEDULE LAB	19,574.00	2,706.00
EKG/ECG	1,077.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,799.00	131.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	172.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,438.00	262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,487.00	1,677.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	298.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	96,023.00	9,242.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,023.00	9,242.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,059.00	ADJUSTMENTS	2,238.09
COVERED CHARGES	205,781.00	CONTRACTUAL ALLOW	190,469.60
NON-COVERD CHARGES	3,278.00	TOTAL MEDICAID LIAB	15,311.40
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	15,134.40

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186,440.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,288.00	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	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,053.00	3,278.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	205,781.00	3,278.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,781.00	3,278.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
920 CAIRO RD
THOMASVILLE,GA 31792-4255

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	196,145.28	ADJUSTMENTS	0.00
COVERED CHARGES	195,235.28	CONTRACTUAL ALLOW	84,649.23
NON-COVERD CHARGES	910.00	TOTAL MEDICAID LIAB	110,586.05
		LESS: COB	1,480.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	109,105.98

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	71	0	32,021.00	0.00
ROUTINE NURSERY	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	71	0	32,021.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	13	0	11,466.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	13	0	11,466.00	0.00
TOTAL ACCOMODATIONS	84	0	43,487.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,234.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,804.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,785.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,956.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,545.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,810.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,975.00	0.00	MRI SERVICES	6,712.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,610.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,586.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	910.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,014.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	876.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,382.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,178.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	214.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	316.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,714.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,609.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	427.00	0.00			

TOTAL ANCILLARY	151,748.28	910.00
TOTAL ACCOMODATIONS	43,487.00	0.00
TOTAL CHARGES	195,235.28	910.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	589,067.44	ADJUSTMENTS	827.90
COVERED CHARGES	523,817.32	CONTRACTUAL ALLOW	347,740.63
NON-COVERD CHARGES	65,250.12	TOTAL MEDICAID LIAB	176,076.69
		LESS: COB	59.84
		LESS: COPAYMENT	744.00
		REIMBURSEMENT	175,272.85
		ALL OTHER	156,767.18
		FEE SCHEDULE-LAB	17,705.49
		INJECTABLE DRUGS	800.18

TOTAL NUMBER OF CLAIMS 733

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,426.09	96.80
MED/SURG SUPPLY	7,569.92	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,124.00	460.00
CT SCAN	87,751.00	13,988.00
PHYSICAL THERAPY	348.00	0.00
EKG/ECG	12,550.00	1,592.00
IV THERAPY	0.00	0.00
OPERATING ROOM	6,408.00	7,273.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	810.00	128.00
ANESTHESIA	0.00	7,800.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	133,608.00	0.00
RECOVERY ROOM	4,380.00	876.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	224.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,082.00	648.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	282.00	575.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,015.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,716.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,065.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	124,105.96	28,020.00
MRI SERVICES	41,322.00	3,706.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,030.35	87.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	523,817.32	65,250.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	523,817.32	65,250.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,194.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,566.00	CONTRACTUAL ALLOW	1,211.54
NON-COVERD CHARGES	2,628.00	TOTAL MEDICAID LIAB	1,354.46
		LESS: COB	1,351.46
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,227.00	1,174.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46.00	1,231.00	FEE SCHEDULE LAB	609.00	211.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	589.00	12.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,566.00	2,628.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,566.00	2,628.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,977.81	ADJUSTMENTS	94.00
COVERED CHARGES	81,507.11	CONTRACTUAL ALLOW	71,907.11
NON-COVERD CHARGES	6,470.70	TOTAL MEDICAID LIAB	9,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	9,228.00

TOTAL NUMBER OF CLAIMS 192

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,200.11	0.00
MED/SURG SUPPLY	286.26	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,565.00	0.00
CT SCAN	10,547.00	2,576.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	675.00	135.00
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	43,293.00	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 SERVICE	534.00	605.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,944.00	3,149.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	462.74	5.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	81,507.11	6,470.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,507.11	6,470.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,142.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,035.10	CONTRACTUAL ALLOW	43.00
NON-COVERD CHARGES	107.00	TOTAL MEDICAID LIAB	992.10
		LESS: COB	992.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	272.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.00	107.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,035.10	107.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,035.10	107.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
PO BOX 1068
FORSYTH,GA 31029-1068

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,082,489.15	ADJUSTMENTS	4,857.63
COVERED CHARGES	1,018,133.53	CONTRACTUAL ALLOW	556,889.26
NON-COVERD CHARGES	64,355.62	TOTAL MEDICAID LIAB	461,244.27
		LESS: COB	3,160.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	458,084.10

TOTAL NUMBER OF ADMISSIONS 67

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	224	3	156,249.00	45,026.06
ROUTINE NURSERY	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	224	3	156,249.00	45,026.06
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	224	3	156,249.00	45,026.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,870.55	0.00	OTHER LAB	9,443.11	0.00
MED/SURG SUPPLY	90,289.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	215,445.79	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,633.18	0.00	OTHER THERAPEUTIC SVC	0.00	18,373.69
CT SCAN	56,368.63	927.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,641.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,325.83	0.00	MRI SERVICES	3,781.05	0.00
IV THERAPY	18,739.43	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,521.93	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	188,767.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,124.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,545.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,314.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,213.80	0.00	INJECTABLE DRUGS	3,436.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	374.38	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	6,186.97	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,334.71	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,819.60	28.07			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,016.78	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/OBSERV. RM	3,689.84	0.00			

TOTAL ANCILLARY	861,884.53	19,329.56
TOTAL ACCOMODATIONS	156,249.00	45,026.06
TOTAL CHARGES	1,018,133.53	64,355.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,132.52	ADJUSTMENTS	0.00
COVERED CHARGES	12,359.00	CONTRACTUAL ALLOW	4,511.50
NON-COVERD CHARGES	773.52	TOTAL MEDICAID LIAB	7,847.50
		LESS: COB	7,847.50
		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	4	0	2,704.00	773.52
ROUTINE NURSERY	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	2,704.00	773.52
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	2,704.00	773.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,079.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,120.42	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,934.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,408.66	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,655.00	0.00
TOTAL ACCOMODATIONS	2,704.00	773.52
TOTAL CHARGES	12,359.00	773.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,334,914.65	ADJUSTMENTS	14,437.43
COVERED CHARGES	2,854,309.61	CONTRACTUAL ALLOW	2,320,669.51
NON-COVERD CHARGES	480,605.04	TOTAL MEDICAID LIAB	533,640.10
		LESS: COB	0.00
		LESS: COPAYMENT	420.00
		REIMBURSEMENT	533,220.10
		ALL OTHER	482,783.80
		FEE SCHEDULE-LAB	48,884.76
		INJECTABLE DRUGS	1,551.54

TOTAL NUMBER OF CLAIMS 1,781

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,766.20	264.10
MED/SURG SUPPLY	109,533.46	4,574.76
LABORATORY-GENERAL	0.00	345.35
RADIOLOGY-DIAGNOSTIC	232,684.87	1,597.24
CT SCAN	419,352.37	70,796.78
PHYSICAL THERAPY	0.00	338.81
EKG/ECG	71,069.08	0.00
IV THERAPY	82,832.64	7,499.02
OPERATING ROOM	20,525.51	9,881.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	88,506.84	11,136.76
ANESTHESIA	11,478.57	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	597,752.58	6,260.76
RECOVERY ROOM	7,980.24	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	507.69
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46.80	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	48,285.37	2,200.24
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	599.88	574.33
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,670.83	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	39,585.58	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	54,893.29	1,916.64

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,988.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	162,324.06
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	843,808.19	195,649.75
MRI SERVICES	69,643.25	4,000.90
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,305.54	736.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,854,309.61	480,605.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,854,309.61	480,605.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,147.42	ADJUSTMENTS	0.00
COVERED CHARGES	6,189.10	CONTRACTUAL ALLOW	1,952.76
NON-COVERD CHARGES	1,958.32	TOTAL MEDICAID LIAB	4,236.34
		LESS: COB	4,236.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92.35	0.00
MED/SURG SUPPLY	43.55	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	1,786.13
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	378.38	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	2,735.41	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	109.23
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,939.41	40.11
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	22.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,189.10	1,958.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,189.10	1,958.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	312,991.53	ADJUSTMENTS	211.76
COVERED CHARGES	275,133.39	CONTRACTUAL ALLOW	255,834.09
NON-COVERD CHARGES	37,858.14	TOTAL MEDICAID LIAB	19,299.30
		LESS: COB	0.00
		LESS: COPAYMENT	756.02
		REIMBURSEMENT	18,543.28

TOTAL NUMBER OF CLAIMS 345

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,825.00	0.00
MED/SURG SUPPLY	3,680.26	108.98
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,856.01	0.00
CT SCAN	7,127.18	4,189.70
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,272.67	0.00
IV THERAPY	8,438.33	390.96
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,247.03	235.75
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	142,370.43	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,885.87	964.38
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,048.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	17,499.17
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	72,902.51	14,469.20
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	479.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	275,133.39	37,858.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	275,133.39	37,858.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,500.19	ADJUSTMENTS	0.00
COVERED CHARGES	5,242.26	CONTRACTUAL ALLOW	2,982.62
NON-COVERD CHARGES	257.93	TOTAL MEDICAID LIAB	2,259.64
		LESS: COB	2,253.64
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	218.46
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,818.02	39.47
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,324.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,242.26	257.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,242.26	257.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-1406

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,312,304.74	ADJUSTMENTS	74,140.91
COVERED CHARGES	5,816,627.85	CONTRACTUAL ALLOW	3,381,156.26
NON-COVERD CHARGES	495,676.89	TOTAL MEDICAID LIAB	2,435,471.59
		LESS: COB	12,065.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,423,406.33

TOTAL NUMBER OF ADMISSIONS 399

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	971	0	513,011.80	10,982.63
ROUTINE NURSERY	380	0	199,708.40	453,630.60
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,351	0	712,720.20	464,613.23
SPECIAL CARE SERVICES				
CCU	1	0	912.08	0.00
ICU	164	0	192,574.72	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	165	0	193,486.80	0.00
TOTAL ACCOMODATIONS	1,516	0	906,207.00	464,613.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	933,958.41	0.00
MED/SURG SUPPLY	789,943.38	0.00
LABORATORY-GENERAL	847,661.13	0.00
RADIOLOGY-DIAGNOSTIC	83,442.06	0.00
CT SCAN	375,209.28	8,309.60
PHYSICAL THERAPY	67,891.56	0.00
EKG/ECG	43,992.84	0.00
IV THERAPY	67,996.94	0.00
OPERATING ROOM	385,481.10	0.00
LABOR/DELIVERY ROOM	66,998.88	0.00
RESPIRATORY SERVICES	114,464.90	0.00
ANESTHESIA	1,928.16	0.00
GI SERVICES	42,875.04	0.00
EMERGENCY ROOM	227,195.72	0.00
RECOVERY ROOM	147,722.64	0.00
LABORATORY PATHOLOGIC	22,253.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	5,496.40	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,769.61	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	57,607.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	102,432.72	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	86,357.28	13,613.60
AUDIOLOGY	4,655.45	0.00
CARDIOLOGY	180,741.60	0.00
AMBULATORY SURGERY	4,790.24	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,140.38	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,112.70	151.32

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,082.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	61,544.08	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	140,675.31	8,077.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	912.08

TOTAL ANCILLARY	4,910,420.85	31,063.66
TOTAL ACCOMODATIONS	906,207.00	464,613.23
TOTAL CHARGES	5,816,627.85	495,676.89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3	2212026001650	12/30/11 - 01/02/12	01/30/12	0.00	912.08	0.00	0.00	0.00
TOTAL				0.00	912.08	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,786,859.31	ADJUSTMENTS	206,614.15
COVERED CHARGES	8,631,658.56	CONTRACTUAL ALLOW	6,753,063.06
NON-COVERD CHARGES	1,155,200.75	TOTAL MEDICAID LIAB	1,878,595.50
		LESS: COB	15,769.40
		LESS: COPAYMENT	4,970.53
		REIMBURSEMENT	1,857,855.57
		ALL OTHER	1,706,388.10
		FEE SCHEDULE-LAB	131,207.29
		INJECTABLE DRUGS	20,260.18

TOTAL NUMBER OF CLAIMS 4,966

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,312.89	2,497.82
MED/SURG SUPPLY	579,099.56	5,221.05
LABORATORY-GENERAL	0.00	696.80
RADIOLOGY-DIAGNOSTIC	408,625.40	12,485.20
CT SCAN	1,254,626.36	243,616.96
PHYSICAL THERAPY	14,899.08	13,791.44
EKG/ECG	90,368.54	350.22
IV THERAPY	238,185.32	820.56
OPERATING ROOM	877,087.63	198,775.58
LABOR/DELIVERY ROOM	5,830.24	0.00
RESPIRATORY SERVICES	44,391.42	57.72
ANESTHESIA	2,892.24	0.00
GI SERVICES	10,074.20	1,703.80
EMERGENCY ROOM	1,683,955.53	3,433.22
RECOVERY ROOM	142,606.88	0.00
LABORATORY PATHOLOGIC	0.00	266.24
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	785.20
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	377.13
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	277,004.60	62,381.32
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,394.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	133,845.59	37,024.82
AUDIOLOGY	0.00	0.00
CARDIOLOGY	127,579.40	28,354.56
AMBULATORY SURGERY	342.16	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	113,417.46	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	227,471.57	836.68

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	40,459.12	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	109.20
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,415,798.64	453,554.51
MRI SERVICES	326,146.08	28,548.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	278,243.85	58,971.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,631,658.56	1,154,659.95
TOTAL ACCOMODATIONS	0.00	540.80
TOTAL CHARGES	8,631,658.56	1,155,200.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,735.14	ADJUSTMENTS	0.00
COVERED CHARGES	37,177.82	CONTRACTUAL ALLOW	23,924.40
NON-COVERD CHARGES	20,557.32	TOTAL MEDICAID LIAB	13,253.42
		LESS: COB	13,233.24
		LESS: COPAYMENT	20.18
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,547.39	0.00
MED/SURG SUPPLY	3,177.34	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,220.96	175.76
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	151.32	0.00
IV THERAPY	736.32	0.00
OPERATING ROOM	3,229.56	9,751.72
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57.98	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,828.26	0.00
RECOVERY ROOM	2,257.84	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 SERVICE	1,360.32	1,060.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	993.20	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,268.44	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,723.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	224.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,940.40	1,875.12
MRI SERVICES	0.00	7,693.92
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	460.15	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,177.82	20,557.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,177.82	20,557.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	858,755.29	ADJUSTMENTS	1,980.66
COVERED CHARGES	771,687.17	CONTRACTUAL ALLOW	725,200.85
NON-COVERD CHARGES	87,068.12	TOTAL MEDICAID LIAB	46,486.32
		LESS: COB	0.00
		LESS: COPAYMENT	1,767.13
		REIMBURSEMENT	44,719.19

TOTAL NUMBER OF CLAIMS 840

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,251.14	46.00
MED/SURG SUPPLY	12,467.51	35.56
LABORATORY-GENERAL	0.00	2,531.36
RADIOLOGY-DIAGNOSTIC	50,160.64	771.94
CT SCAN	68,499.52	13,712.64
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,027.28	0.00
IV THERAPY	19,272.36	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	613.60	0.00
RESPIRATORY SERVICES	1,292.76	32.76
ANESTHESIA	321.36	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	406,139.74	418.80
RECOVERY ROOM	917.28	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	29.01	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,650.64	5,436.08
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,635.84	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,338.48
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,654.08	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,805.92	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,160.56	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	147,410.72	60,382.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,377.21	2,362.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	771,687.17	87,068.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	771,687.17	87,068.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,645.87	ADJUSTMENTS	0.00
COVERED CHARGES	8,524.02	CONTRACTUAL ALLOW	6,211.02
NON-COVERD CHARGES	1,121.85	TOTAL MEDICAID LIAB	2,313.00
		LESS: COB	2,301.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	478.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	132.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	162.24	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,859.52	357.76
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	614.64	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,035.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40.24	71.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	362.96	530.40			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,524.02	1,121.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,524.02	1,121.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338,303.93	ADJUSTMENTS	24,698.81
COVERED CHARGES	306,723.53	CONTRACTUAL ALLOW	242,409.25
NON-COVERD CHARGES	31,580.40	TOTAL MEDICAID LIAB	64,314.28
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	64,263.28

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,768.25	0.00
MED/SURG SUPPLY	109,623.16	2,814.24
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,584.80	559.52
CT SCAN	0.00	4,621.80
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	217.88	0.00
IV THERAPY	204.88	0.00
OPERATING ROOM	131,443.64	17,358.64
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	595.40	0.00
ANESTHESIA	321.36	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	645.83	0.00
RECOVERY ROOM	10,303.28	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 SERVICE	1,594.32	775.84
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,736.16	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,655.92	4,065.36
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,028.65	1,385.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	306,723.53	31,580.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	306,723.53	31,580.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,783,753.17	ADJUSTMENTS	9,704,530.43
COVERED CHARGES	65,844,206.67	CONTRACTUAL ALLOW	47,272,597.69
NON-COVERD CHARGES	2,939,546.50	TOTAL MEDICAID LIAB	18,571,608.98
		LESS: COB	238,474.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,333,134.89

TOTAL NUMBER OF ADMISSIONS 3,052

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,649	16	4,427,960.00	691,931.00
ROUTINE NURSERY	5,270	4	7,238,075.00	1,189,458.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	7	0.00	0.00
TOTAL ROUTINE	10,919	27	11,666,035.00	1,881,389.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,900	5	5,257,308.00	14,485.00
NICU	820	0	3,661,256.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,720	5	8,918,564.00	14,485.00
TOTAL ACCOMODATIONS	13,639	32	20,584,599.00	1,895,874.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,643,233.25	89,671.50
MED/SURG SUPPLY	3,431,291.50	126,746.00
LABORATORY-GENERAL	6,766,982.93	20,115.00
RADIOLOGY-DIAGNOSTIC	828,641.00	0.00
CT SCAN	944,771.00	0.00
PHYSICAL THERAPY	258,131.50	232.00
EKG/ECG	136,957.00	0.00
IV THERAPY	28,574.00	13,115.00
OPERATING ROOM	3,336,242.00	131,189.00
LABOR/DELIVERY ROOM	3,740,196.00	0.00
RESPIRATORY SERVICES	3,085,564.50	8,240.00
ANESTHESIA	594,158.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	810,647.00	29,467.00
RECOVERY ROOM	540,860.00	0.00
LABORATORY PATHOLOGIC	510,073.00	0.00
RADIOLOGY THERAPEUTIC	78,197.00	1,458.00
OCCUPATIONAL THERAPY	203,043.50	0.00
SPEECH PATHOLOGY	136,459.00	0.00
RENAL DIALYSIS	182,800.00	28,174.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	58.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	52,275.00	0.00
OTHER IMAGING SERVICE	447,278.50	26,434.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,413,652.50	398,015.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	153,988.00	15,137.00
AUDIOLOGY	289,247.00	0.00
CARDIOLOGY	707,890.50	2,513.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	24,887.00	0.00
ORGAN ACQUISITION	116,199.99	0.00
TREATMENT/OBSERV. RM	20,600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	331,856.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,933.00	747.00
OTHER THERAPEUTIC SVC	317.00	28,988.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	417,874.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	571.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	4,604.00
DRUG-SPECIFIC/HOME IV	0.00	23,086.50
INJECTABLE DRUGS	13,022,729.00	91,907.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	3,262.00

TOTAL ANCILLARY	45,259,607.67	1,043,672.50
TOTAL ACCOMODATIONS	20,584,599.00	1,895,874.00
TOTAL CHARGES	65,844,206.67	2,939,546.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2211334006401	01/01/11 - 01/04/11	12/05/11	0.00	3,262.00	0.00	0.00	0.00
TOTAL				0.00	3,262.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,736,719.54	ADJUSTMENTS	0.00
COVERED CHARGES	6,465,902.54	CONTRACTUAL ALLOW	3,124,871.94
NON-COVERD CHARGES	270,817.00	TOTAL MEDICAID LIAB	3,341,030.60
		LESS: COB	3,341,030.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 113

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	213	5	167,967.00	36,897.00
ROUTINE NURSERY	587	0	1,446,044.00	155,298.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	800	5	1,614,011.00	192,195.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	95	0	250,162.00	0.00
NICU	325	0	1,449,717.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	420	0	1,699,879.00	0.00
TOTAL ACCOMODATIONS	1,220	5	3,313,890.00	192,195.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,065.50	0.00	OTHER LAB	44,967.00	0.00
MED/SURG SUPPLY	258,540.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	411,183.04	0.00	EDUCATION & TRAINING	747.00	0.00
RADIOLOGY-DIAGNOSTIC	130,106.00	0.00	OTHER THERAPEUTIC SVC	504.00	5,292.00
CT SCAN	11,384.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,402.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,968.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	146,027.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	213,173.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	778,094.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,750.00	0.00	SPECIAL SERVICES	0.00	72,197.00
RECOVERY ROOM	21,621.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,717.00	0.00	INJECTABLE DRUGS	651,902.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,536.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,548.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,796.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	23,765.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,745.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,236.00	1,133.00			
AUDIOLOGY	18,500.00	0.00			
CARDIOLOGY	46,227.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	334.00	0.00			

TOTAL ANCILLARY	3,152,012.54	78,622.00
TOTAL ACCOMODATIONS	3,313,890.00	192,195.00
TOTAL CHARGES	6,465,902.54	270,817.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,317,707.06	ADJUSTMENTS	572,897.83
COVERED CHARGES	12,715,440.29	CONTRACTUAL ALLOW	10,169,145.47
NON-COVERD CHARGES	2,602,266.77	TOTAL MEDICAID LIAB	2,546,294.82
		LESS: COB	28,973.44
		LESS: COPAYMENT	8,880.39
		REIMBURSEMENT	2,508,440.99
		ALL OTHER	2,181,771.71
		FEE SCHEDULE-LAB	192,264.79
		INJECTABLE DRUGS	134,404.49

TOTAL NUMBER OF CLAIMS 4,544

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311,667.10	8,369.00
MED/SURG SUPPLY	577,800.50	26,141.00
LABORATORY-GENERAL	0.00	294.00
RADIOLOGY-DIAGNOSTIC	322,902.00	13,190.00
CT SCAN	719,752.00	60,868.00
PHYSICAL THERAPY	3,399.00	1,941.00
EKG/ECG	73,062.00	0.00
IV THERAPY	371,351.00	49,556.00
OPERATING ROOM	1,052,483.00	203,686.00
LABOR/DELIVERY ROOM	273,048.00	2,572.00
RESPIRATORY SERVICES	12,113.00	111.00
ANESTHESIA	289,359.00	11,500.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,856,141.00	50,495.00
RECOVERY ROOM	309,974.00	1,623.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	292,685.00	5,124.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	9,140.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,007.00	263.00
PSYCHIATRIC SERVICES	209,895.00	103,014.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,211,083.00	204,997.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	305,451.00	156,367.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	84,132.00	11,144.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	104,484.00	1,072.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	575.00	0.00
ORGAN ACQUISITION	0.00	64,816.17
TREATMENT/OBSERV. RM	219,372.00	2,096.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	56,965.00	3,138.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,233.00	330.00
OTHER THERAPEUTIC SVC	0.00	37,801.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,523,164.19	332,711.60
MRI SERVICES	297,529.00	10,534.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	95.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	138.00
DRUG-SPECIFIC/HOME IV	0.00	997.00
INJECTABLE DRUGS	1,230,813.50	1,228,143.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,715,440.29	2,602,266.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,715,440.29	2,602,266.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	964,364.75	ADJUSTMENTS	0.00
COVERED CHARGES	585,021.25	CONTRACTUAL ALLOW	141,912.88
NON-COVERD CHARGES	379,343.50	TOTAL MEDICAID LIAB	443,108.37
		LESS: COB	442,640.54
		LESS: COPAYMENT	467.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 264

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,839.50	1,047.00	OTHER LAB	5,475.00	0.00
MED/SURG SUPPLY	36,543.00	109,955.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	375.00	0.00
RADIOLOGY-DIAGNOSTIC	10,794.00	0.00	OTHER THERAPEUTIC SVC	417.00	2,641.00
CT SCAN	14,360.00	17,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	975.00	FEE SCHEDULE LAB	110,851.75	32,856.00
EKG/ECG	1,968.00	0.00	MRI SERVICES	9,433.00	0.00
IV THERAPY	12,173.00	403.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,509.00	71,320.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	56,646.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	496.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,839.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,420.00	1,919.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,597.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,837.00	31,659.50
RADIOLOGY THERAPEUTIC	1,481.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	18,689.00	21,636.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	99,317.00	79,675.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,649.00	7,657.00			
AUDIOLOGY	232.00	0.00			
CARDIOLOGY	5,328.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,752.00	0.00			

TOTAL ANCILLARY	585,021.25	379,343.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	585,021.25	379,343.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	448,289.50	ADJUSTMENTS	1,403.44
COVERED CHARGES	414,348.50	CONTRACTUAL ALLOW	398,181.85
NON-COVERD CHARGES	33,941.00	TOTAL MEDICAID LIAB	16,166.65
		LESS: COB	0.00
		LESS: COPAYMENT	513.00
		REIMBURSEMENT	15,653.65

TOTAL NUMBER OF CLAIMS 289

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,843.50	123.50	OTHER LAB	1,887.00	992.00
MED/SURG SUPPLY	4,251.00	51.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,218.00	311.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,063.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,348.00	10,454.00
EKG/ECG	3,444.00	0.00	MRI SERVICES	19,302.00	6,524.00
IV THERAPY	1,184.00	1,084.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,944.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	221,577.00	2,629.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,722.00	5,623.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	37,799.00	4,721.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,040.00	1,428.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,726.00	0.00			

TOTAL ANCILLARY	414,348.50	33,941.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	414,348.50	33,941.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,636.50	ADJUSTMENTS	0.00
COVERED CHARGES	13,526.00	CONTRACTUAL ALLOW	9,064.29
NON-COVERD CHARGES	1,110.50	TOTAL MEDICAID LIAB	4,461.71
		LESS: COB	4,452.71
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	644.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	637.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,861.00	352.00
EKG/ECG	246.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	757.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,759.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	112.00	89.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	468.00	669.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,526.00	1,110.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,526.00	1,110.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,357,587.40	ADJUSTMENTS	215,916.26
COVERED CHARGES	2,993,129.90	CONTRACTUAL ALLOW	2,475,609.42
NON-COVERD CHARGES	364,457.50	TOTAL MEDICAID LIAB	517,520.48
		LESS: COB	1,736.00
		LESS: COPAYMENT	876.84
		REIMBURSEMENT	514,907.64

TOTAL NUMBER OF CLAIMS 104

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,686.50	2,226.00
MED/SURG SUPPLY	351,958.00	3,538.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,283.00	4,086.00
CT SCAN	71,401.00	5,240.00
PHYSICAL THERAPY	0.00	733.00
EKG/ECG	3,924.00	0.00
IV THERAPY	95,089.00	7,889.00
OPERATING ROOM	380,473.00	47,202.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,052.00	0.00
ANESTHESIA	82,383.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,471.00	813.00
RECOVERY ROOM	45,507.00	1,484.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	278,630.00	33,658.00
OCCUPATIONAL THERAPY	0.00	584.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	89.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	34,850.00	0.00
OTHER IMAGING SERVICE	5,698.00	669.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	66,940.00	26,130.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,130.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	40,717.00	19,286.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	3,398.00
TREATMENT/OBSERV. RM	35,420.00	1,523.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,181.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,269.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	219,988.90	13,738.50
MRI SERVICES	14,544.00	4,010.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	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	1,131,714.50	181,889.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,993,129.90	364,457.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,993,129.90	364,457.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	85,442.00	ADJUSTMENTS	0.00
COVERED CHARGES	53,392.50	CONTRACTUAL ALLOW	7,092.84
NON-COVERD CHARGES	32,049.50	TOTAL MEDICAID LIAB	46,299.66
		LESS: COB	46,296.66
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,801.50	170.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,043.00	10,996.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,031.00	20,647.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,962.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,312.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	536.00	236.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	707.00	0.00			

TOTAL ANCILLARY	53,392.50	32,049.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,392.50	32,049.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,825,285.30	ADJUSTMENTS	245,402.43
COVERED CHARGES	7,690,431.80	CONTRACTUAL ALLOW	5,354,994.73
NON-COVERD CHARGES	134,853.50	TOTAL MEDICAID LIAB	2,335,437.07
		LESS: COB	19,934.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,315,502.92

TOTAL NUMBER OF ADMISSIONS 264

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,189	0	583,799.00	57,024.00
ROUTINE NURSERY	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	1,189	0	583,799.00	57,024.00
SPECIAL CARE SERVICES				
CCU	121	0	154,163.00	0.00
ICU	177	0	228,507.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	298	0	382,670.00	0.00
TOTAL ACCOMODATIONS	1,487	0	966,469.00	57,024.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,157,558.00	0.00
MED/SURG SUPPLY	533,050.90	0.00
LABORATORY-GENERAL	1,141,175.40	137.00
RADIOLOGY-DIAGNOSTIC	221,068.00	0.00
CT SCAN	349,827.00	1,322.50
PHYSICAL THERAPY	80,409.00	0.00
EKG/ECG	38,226.50	0.00
IV THERAPY	11,551.00	0.00
OPERATING ROOM	424,434.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	386,346.00	0.00
ANESTHESIA	115,566.00	0.00
GI SERVICES	112,112.00	0.00
EMERGENCY ROOM	541,357.00	0.00
RECOVERY ROOM	84,519.00	0.00
LABORATORY PATHOLOGIC	32,152.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,405.50	0.00
SPEECH PATHOLOGY	11,604.50	0.00
RENAL DIALYSIS	17,415.00	29,877.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,175.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	47,217.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	68,830.00	1,083.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,330.50	675.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	55,385.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,289.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,460.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	35,218.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	73,792.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	40,775.00
INJECTABLE DRUGS	1,116,487.50	1,237.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,722.00

TOTAL ANCILLARY	6,723,962.80	77,829.50
TOTAL ACCOMODATIONS	966,469.00	57,024.00
TOTAL CHARGES	7,690,431.80	134,853.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	4010260054456	09/02/10 - 09/02/10	09/20/10	0.00	731.00	0.00	0.00	0.00
615	4010267063052	09/08/10 - 09/08/10	09/27/10	0.00	731.00	0.00	0.00	0.00
615	4410259077261	08/05/10 - 08/05/10	09/27/10	0.00	630.00	0.00	0.00	0.00
615	2010320026886	10/18/10 - 10/23/10	11/22/10	0.00	630.00	0.00	0.00	0.00
TOTAL				0.00	2,722.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,763,150.30	ADJUSTMENTS	299,567.65
COVERED CHARGES	7,203,853.42	CONTRACTUAL ALLOW	5,710,771.42
NON-COVERD CHARGES	559,296.88	TOTAL MEDICAID LIAB	1,493,082.00
		LESS: COB	2,216.77
		LESS: COPAYMENT	1,752.00
		REIMBURSEMENT	1,489,113.23
		ALL OTHER	1,354,101.28
		FEE SCHEDULE-LAB	81,710.44
		INJECTABLE DRUGS	53,301.51

TOTAL NUMBER OF CLAIMS 2,942

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329,548.00	1,282.00
MED/SURG SUPPLY	267,353.50	26,019.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	729,336.00	4,859.00
CT SCAN	667,151.50	55,774.50
PHYSICAL THERAPY	11,739.50	3,134.00
EKG/ECG	64,848.50	0.00
IV THERAPY	31,455.00	0.00
OPERATING ROOM	680,187.35	275,952.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	42,577.50	0.00
ANESTHESIA	256,277.00	0.00
GI SERVICES	65,728.50	4,410.75
EMERGENCY ROOM	2,440,036.50	7,944.00
RECOVERY ROOM	337,605.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,374.00	0.00
OCCUPATIONAL THERAPY	3,355.00	7,500.00
SPEECH PATHOLOGY	0.00	758.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,112.00	217.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	39,643.00	0.00
OTHER IMAGING SERVICE	91,947.50	1,760.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,049.00	212.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	62,356.00	9,903.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,621.00	1,214.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	659.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	18,024.00	1,615.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	10,815.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	707,467.17	88,502.50
MRI SERVICES	33,650.50	8,018.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	600.00
INJECTABLE DRUGS	295,935.40	58,359.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,260.00

TOTAL ANCILLARY	7,203,853.42	559,296.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,203,853.42	559,296.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	4010287027888	09/30/10 - 09/30/10	10/18/10	0.00	630.00	0.00	0.00	0.00
615	2011026028180	01/21/11 - 01/21/11	01/31/11	0.00	630.00	0.00	0.00	0.00
TOTAL				0.00	1,260.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,032.50	ADJUSTMENTS	0.00
COVERED CHARGES	80,849.33	CONTRACTUAL ALLOW	26,907.24
NON-COVERD CHARGES	39,183.17	TOTAL MEDICAID LIAB	53,942.09
		LESS: COB	53,921.09
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,674.50	0.00
MED/SURG SUPPLY	3,437.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,778.00	0.00
CT SCAN	0.00	7,932.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	378.50	0.00
IV THERAPY	377.50	0.00
OPERATING ROOM	4,433.33	22,497.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	407.00	0.00
ANESTHESIA	10,691.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,418.50	504.00
RECOVERY ROOM	10,531.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	362.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,819.50	4,678.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	723.00	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,064.50	1,412.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,115.50	1,556.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	80,849.33	39,183.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,849.33	39,183.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	943,889.10	ADJUSTMENTS	7,519.59
COVERED CHARGES	927,284.60	CONTRACTUAL ALLOW	882,900.36
NON-COVERD CHARGES	16,604.50	TOTAL MEDICAID LIAB	44,384.24
		LESS: COB	0.00
		LESS: COPAYMENT	1,659.01
		REIMBURSEMENT	42,725.23

TOTAL NUMBER OF CLAIMS 805

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,073.50	99.00
MED/SURG SUPPLY	5,733.10	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,935.50	0.00
CT SCAN	32,633.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,437.00	0.00
IV THERAPY	3,764.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,493.50	0.00
ANESTHESIA	346.50	0.00
GI SERVICES	3,201.00	0.00
EMERGENCY ROOM	662,502.00	845.50
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 SERVICE	15,131.00	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/OBSERV. RM	110.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	519.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	84,358.50	10,607.00
MRI SERVICES	3,195.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,851.50	4,813.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	927,284.60	16,604.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	927,284.60	16,604.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,775.50	ADJUSTMENTS	0.00
COVERED CHARGES	13,534.50	CONTRACTUAL ALLOW	7,749.32
NON-COVERD CHARGES	241.00	TOTAL MEDICAID LIAB	5,785.18
		LESS: COB	5,779.18
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	814.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	713.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	988.00	241.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,216.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	188.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,548.50	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,534.50	241.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,534.50	241.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	349,059.62	ADJUSTMENTS	5,403.46
COVERED CHARGES	302,889.12	CONTRACTUAL ALLOW	252,532.38
NON-COVERD CHARGES	46,170.50	TOTAL MEDICAID LIAB	50,356.74
		LESS: COB	2,366.40
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	47,957.34

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,548.50	7,200.00
MED/SURG SUPPLY	139,802.60	9,268.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,656.00	0.00
CT SCAN	4,327.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	923.50	0.00
IV THERAPY	289.50	0.00
OPERATING ROOM	72,404.52	24,371.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	20,478.50	0.00
GI SERVICES	0.00	3,557.00
EMERGENCY ROOM	2,343.00	0.00
RECOVERY ROOM	19,538.50	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	726.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	993.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,617.50	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,966.50	1,048.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	302,889.12	46,170.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	302,889.12	46,170.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
417 THIRD AVE
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	350,485.75	ADJUSTMENTS	5,992.86
COVERED CHARGES	345,515.75	CONTRACTUAL ALLOW	223,080.62
NON-COVERD CHARGES	4,970.00	TOTAL MEDICAID LIAB	122,435.13
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	122,435.13

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	106	0	45,580.00	4,970.00
ROUTINE NURSERY	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	106	0	45,580.00	4,970.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	106	0	45,580.00	4,970.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,773.75	0.00	OTHER LAB	2,285.00	0.00
MED/SURG SUPPLY	33,272.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,719.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,486.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,218.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,176.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,365.00	0.00	MRI SERVICES	5,741.00	0.00
IV THERAPY	5,846.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,731.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,800.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,375.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,379.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	270.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	670.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,604.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,899.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,430.00	0.00			

TOTAL ANCILLARY	299,935.75	0.00
TOTAL ACCOMODATIONS	45,580.00	4,970.00
TOTAL CHARGES	345,515.75	4,970.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	965,854.40	ADJUSTMENTS	19,899.53
COVERED CHARGES	836,401.25	CONTRACTUAL ALLOW	580,047.21
NON-COVERD CHARGES	129,453.15	TOTAL MEDICAID LIAB	256,354.04
		LESS: COB	154.71
		LESS: COPAYMENT	1,056.00
		REIMBURSEMENT	255,143.33
		ALL OTHER	226,639.63
		FEE SCHEDULE-LAB	28,026.43
		INJECTABLE DRUGS	477.27

TOTAL NUMBER OF CLAIMS 1,003

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,275.25	1,237.00
MED/SURG SUPPLY	39,671.00	265.00
LABORATORY-GENERAL	0.00	2,270.00
RADIOLOGY-DIAGNOSTIC	32,358.00	1,067.00
CT SCAN	73,601.00	29,856.00
PHYSICAL THERAPY	7,332.00	600.00
EKG/ECG	9,555.00	420.00
IV THERAPY	26,771.00	1,580.00
OPERATING ROOM	29,065.00	1,923.00
LABOR/DELIVERY ROOM	496.00	248.00
RESPIRATORY SERVICES	6,904.00	389.00
ANESTHESIA	4,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	210,967.00	353.00
RECOVERY ROOM	4,888.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	14,095.00	2,686.00
SPEECH PATHOLOGY	1,090.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	921.00	510.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,497.00	742.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,723.00	2,375.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,732.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,020.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,475.00	2,230.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,475.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	211,257.00	72,565.70
MRI SERVICES	14,674.00	2,411.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	205.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,305.00	2,231.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	644.00

TOTAL ANCILLARY	836,401.25	126,603.15
TOTAL ACCOMODATIONS	0.00	2,850.00
TOTAL CHARGES	836,401.25	129,453.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
19	4010294033339	09/21/10 - 09/21/10	10/25/10	0.00	342.00	0.00	0.00	0.00
701	2210351018967	12/02/10 - 12/02/10	12/20/10	0.00	302.00	0.00	0.00	0.00
TOTAL				0.00	644.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,969.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,518.00	CONTRACTUAL ALLOW	2,795.40
NON-COVERD CHARGES	1,451.00	TOTAL MEDICAID LIAB	1,722.60
		LESS: COB	1,720.39
		LESS: COPAYMENT	2.21
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,438.00	579.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,054.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	872.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	781.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,518.00	1,451.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,518.00	1,451.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	142,723.00	ADJUSTMENTS	311.00
COVERED CHARGES	137,886.00	CONTRACTUAL ALLOW	128,293.95
NON-COVERD CHARGES	4,837.00	TOTAL MEDICAID LIAB	9,592.05
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	9,175.05

TOTAL NUMBER OF CLAIMS 212

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,434.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,719.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,866.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,570.00	1,641.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,532.00	2,203.00
EKG/ECG	840.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	393.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,012.00	153.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	30.00	0.00
EMERGENCY ROOM	94,179.00	585.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,437.00	255.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	710.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	135.00	0.00			

TOTAL ANCILLARY	137,886.00	4,837.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,886.00	4,837.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,610.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,572.00	CONTRACTUAL ALLOW	468.36
NON-COVERD CHARGES	38.00	TOTAL MEDICAID LIAB	1,103.64
		LESS: COB	1,103.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	178.00	38.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,572.00	38.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,572.00	38.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL
PATTERSON HOSP. SOUTHWEST GA
CUTHBERT,GA 39840-1338

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,881,327.44	ADJUSTMENTS	91,820.27
COVERED CHARGES	2,848,320.44	CONTRACTUAL ALLOW	1,852,503.90
NON-COVERD CHARGES	33,007.00	TOTAL MEDICAID LIAB	995,816.54
		LESS: COB	2,264.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	993,551.91

TOTAL NUMBER OF ADMISSIONS 147

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	298	0	278,928.00	30,858.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	298	1	278,928.00	30,858.00
SPECIAL CARE SERVICES				
CCU	109	0	155,680.00	0.00
ICU	35	0	81,235.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	144	0	236,915.00	0.00
TOTAL ACCOMODATIONS	442	1	515,843.00	30,858.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	431,719.02	0.00
MED/SURG SUPPLY	157,988.00	27.00
LABORATORY-GENERAL	537,164.00	0.00
RADIOLOGY-DIAGNOSTIC	73,617.00	0.00
CT SCAN	292,753.00	0.00
PHYSICAL THERAPY	6,303.00	0.00
EKG/ECG	29,290.00	0.00
IV THERAPY	10,693.00	0.00
OPERATING ROOM	82,777.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	163,274.00	0.00
ANESTHESIA	31,653.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	271,614.00	0.00
RECOVERY ROOM	18,370.00	0.00
LABORATORY PATHOLOGIC	8,717.40	0.00
RADIOLOGY THERAPEUTIC	2,562.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	402.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	700.00	733.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	26,675.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,626.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,335.00	1,389.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	96,326.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	995.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,640.02	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	27,862.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	25,188.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	234.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,332,477.44	2,149.00
TOTAL ACCOMODATIONS	515,843.00	30,858.00
TOTAL CHARGES	2,848,320.44	33,007.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,904,267.56	ADJUSTMENTS	197,420.19
COVERED CHARGES	5,572,618.85	CONTRACTUAL ALLOW	4,466,994.31
NON-COVERD CHARGES	331,648.71	TOTAL MEDICAID LIAB	1,105,624.54
		LESS: COB	2,694.70
		LESS: COPAYMENT	2,550.90
		REIMBURSEMENT	1,100,378.94
		ALL OTHER	1,001,778.31
		FEE SCHEDULE-LAB	64,879.90
		INJECTABLE DRUGS	33,720.73

TOTAL NUMBER OF CLAIMS 2,516

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	228,050.49	145.00
MED/SURG SUPPLY	64,660.00	147.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	389,266.00	4,341.00
CT SCAN	1,116,885.00	84,832.00
PHYSICAL THERAPY	0.00	380.00
EKG/ECG	61,920.00	0.00
IV THERAPY	58,641.00	473.00
OPERATING ROOM	146,280.00	9,152.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	52,947.00	15,611.00
ANESTHESIA	44,963.00	1,104.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,652,870.00	16,214.00
RECOVERY ROOM	31,267.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	61,915.00	737.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,343.00	1,600.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	164,800.00	11,864.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,712.00	4,230.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,741.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,624.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,559.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	20,708.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	32,089.00	5,866.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	376.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	889,917.42	123,037.00
MRI SERVICES	295,622.00	24,396.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	173,462.50	27,389.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	130.00

TOTAL ANCILLARY	5,572,618.85	331,648.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,572,618.85	331,648.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3050	4010250078781	07/31/10 - 07/31/10	09/27/10	0.00	130.00	0.00	0.00	0.00
TOTAL				0.00	130.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,335.00	ADJUSTMENTS	0.00
COVERED CHARGES	86,089.25	CONTRACTUAL ALLOW	33,263.74
NON-COVERD CHARGES	13,245.75	TOTAL MEDICAID LIAB	52,825.51
		LESS: COB	52,805.22
		LESS: COPAYMENT	20.29
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,285.25	16.50
MED/SURG SUPPLY	467.00	11.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,961.00	456.00
CT SCAN	7,305.00	2,000.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	431.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	1,880.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	265.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,491.00	890.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,798.00	2,239.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,057.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	895.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,811.00	1,022.00
MRI SERVICES	7,218.00	3,447.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	389.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	86,089.25	13,245.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,089.25	13,245.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	600,880.25	ADJUSTMENTS	4,202.32
COVERED CHARGES	580,076.25	CONTRACTUAL ALLOW	551,352.85
NON-COVERD CHARGES	20,804.00	TOTAL MEDICAID LIAB	28,723.40
		LESS: COB	0.00
		LESS: COPAYMENT	981.00
		REIMBURSEMENT	27,742.40

TOTAL NUMBER OF CLAIMS 515

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,574.00	0.00
MED/SURG SUPPLY	2,291.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,212.00	0.00
CT SCAN	64,868.00	5,122.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,898.00	0.00
IV THERAPY	686.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,085.00	796.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	326,538.00	1,865.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	427.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	56.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,768.00	653.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,658.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90,974.00	12,312.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	97.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	580,076.25	20,804.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	580,076.25	20,804.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,249.25	ADJUSTMENTS	0.00
COVERED CHARGES	22,082.25	CONTRACTUAL ALLOW	13,462.62
NON-COVERD CHARGES	167.00	TOTAL MEDICAID LIAB	8,619.63
		LESS: COB	8,613.63
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	513.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	104.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	814.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,754.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,700.00	97.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,141.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,056.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,082.25	167.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,082.25	167.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,223.00	ADJUSTMENTS	0.00
COVERED CHARGES	68,223.00	CONTRACTUAL ALLOW	57,792.62
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,430.38
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	10,373.38

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,436.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	66,787.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	68,223.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,223.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL
PO BOX 406168
ATLANTA,GA 30384-6168

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	580,279.00	ADJUSTMENTS	10,068.25
COVERED CHARGES	575,469.00	CONTRACTUAL ALLOW	186,044.01
NON-COVERD CHARGES	4,810.00	TOTAL MEDICAID LIAB	389,424.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	389,424.99

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	206	0	71,940.00	4,810.00
ROUTINE NURSERY	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	206	0	71,940.00	4,810.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	206	0	71,940.00	4,810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,760.00	0.00
MED/SURG SUPPLY	25,119.00	0.00
LABORATORY-GENERAL	145,853.00	0.00
RADIOLOGY-DIAGNOSTIC	9,649.00	0.00
CT SCAN	33,576.00	0.00
PHYSICAL THERAPY	932.00	0.00
EKG/ECG	11,449.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,150.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,257.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	43,606.00	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 SERVICE	6,410.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,984.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,688.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,364.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,630.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,102.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	503,529.00	0.00
TOTAL ACCOMODATIONS	71,940.00	4,810.00
TOTAL CHARGES	575,469.00	4,810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,927,346.80	ADJUSTMENTS	16,141.86
COVERED CHARGES	1,699,445.00	CONTRACTUAL ALLOW	1,182,777.87
NON-COVERD CHARGES	227,901.80	TOTAL MEDICAID LIAB	516,667.13
		LESS: COB	0.00
		LESS: COPAYMENT	2,142.00
		REIMBURSEMENT	514,525.13
		ALL OTHER	427,989.15
		FEE SCHEDULE-LAB	83,766.31
		INJECTABLE DRUGS	2,769.67

TOTAL NUMBER OF CLAIMS 2,446

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,100.00	5,834.00
MED/SURG SUPPLY	56,478.00	486.00
LABORATORY-GENERAL	0.00	100.00
RADIOLOGY-DIAGNOSTIC	125,983.00	957.00
CT SCAN	161,009.00	13,695.00
PHYSICAL THERAPY	4,710.00	1,430.00
EKG/ECG	38,051.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	83,149.00	789.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,304.00	4,146.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	368,015.00	418.00
RECOVERY ROOM	13,995.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	70.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	47,716.00	671.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,110.00	1,456.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,048.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,571.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17,456.00	315.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	25,033.00	1,530.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	442.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	546,266.00	156,419.80
MRI SERVICES	23,831.00	1,437.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	62,620.00	37,706.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,699,445.00	227,901.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,699,445.00	227,901.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,694.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,323.00	CONTRACTUAL ALLOW	1,867.43
NON-COVERD CHARGES	1,371.00	TOTAL MEDICAID LIAB	3,455.57
		LESS: COB	3,452.57
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.00	31.00
MED/SURG SUPPLY	519.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	321.00	0.00
IV THERAPY	0.00	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	1,790.00	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 SERVICE	0.00	432.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,451.00	886.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	22.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,323.00	1,371.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,323.00	1,371.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107,412.00	ADJUSTMENTS	451.05
COVERED CHARGES	102,899.00	CONTRACTUAL ALLOW	87,300.49
NON-COVERD CHARGES	4,513.00	TOTAL MEDICAID LIAB	15,598.51
		LESS: COB	0.00
		LESS: COPAYMENT	657.03
		REIMBURSEMENT	14,941.48

TOTAL NUMBER OF CLAIMS 335

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,914.00	120.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,831.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,762.00	93.00	OTHER THERAPEUTIC SVC	0.00	26.00
CT SCAN	925.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,320.00	2,136.00
EKG/ECG	321.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	732.00	36.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,368.00	99.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,550.00	2,003.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	176.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	102,899.00	4,513.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	102,899.00	4,513.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,315.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,894.00	CONTRACTUAL ALLOW	366.31
NON-COVERD CHARGES	421.00	TOTAL MEDICAID LIAB	1,527.69
		LESS: COB	1,518.69
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44.00	46.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375.00	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	1,033.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	329.00	149.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	113.00	226.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,894.00	421.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,894.00	421.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,184.00	ADJUSTMENTS	0.00
COVERED CHARGES	29,318.00	CONTRACTUAL ALLOW	24,924.83
NON-COVERD CHARGES	866.00	TOTAL MEDICAID LIAB	4,393.17
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	4,336.17

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	958.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	670.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	695.00	866.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,755.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,133.00	0.00			

TOTAL ANCILLARY	29,318.00	866.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,318.00	866.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PEACH REGIONAL MEDICAL CENTER
PO BOX 1799
FORT VALLEY,GA 31030-1799

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/10 THROUGH 10/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,094,101.27	ADJUSTMENTS	80,331.28
COVERED CHARGES	1,070,150.86	CONTRACTUAL ALLOW	561,034.94
NON-COVERD CHARGES	23,950.41	TOTAL MEDICAID LIAB	509,115.92
		LESS: COB	14,684.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	494,431.49

TOTAL NUMBER OF ADMISSIONS 67

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	305	0	175,213.00	11,888.00
ROUTINE NURSERY	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	305	0	175,213.00	11,888.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	21	0	36,060.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	21	0	36,060.00	0.00
TOTAL ACCOMODATIONS	326	0	211,273.00	11,888.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173,167.17	0.00
MED/SURG SUPPLY	30,251.74	64.71
LABORATORY-GENERAL	226,877.92	123.55
RADIOLOGY-DIAGNOSTIC	39,873.27	0.00
CT SCAN	114,588.29	0.00
PHYSICAL THERAPY	13,141.04	0.00
EKG/ECG	14,951.32	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,991.55	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	55,628.53	0.00
ANESTHESIA	4,303.63	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,077.11	796.29
RECOVERY ROOM	5,127.77	0.00
LABORATORY PATHOLOGIC	2,947.06	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,757.59	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	168.72	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,645.21	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,702.40	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,147.30	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,386.07	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,593.99	169.53

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	15,282.55	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	66.69	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	21,200.94	7,868.84
PROFESSIONAL FEES	0.00	59.40
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,980.09

TOTAL ANCILLARY	858,877.86	12,062.41
TOTAL ACCOMODATIONS	211,273.00	11,888.00
TOTAL CHARGES	1,070,150.86	23,950.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	9112023000355	08/08/11 - 08/17/11	01/30/12	0.00	2,980.09	0.00	2,230.78	0.00
TOTAL				0.00	2,980.09	0.00	2,230.78	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,752,746.12	ADJUSTMENTS	54,928.45
COVERED CHARGES	1,537,322.40	CONTRACTUAL ALLOW	1,184,033.91
NON-COVERD CHARGES	215,423.72	TOTAL MEDICAID LIAB	353,288.49
		LESS: COB	1,256.14
		LESS: COPAYMENT	1,779.00
		REIMBURSEMENT	350,253.35
		ALL OTHER	305,525.06
		FEE SCHEDULE-LAB	41,604.98
		INJECTABLE DRUGS	3,123.31

TOTAL NUMBER OF CLAIMS 1,357

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,775.70	0.00
MED/SURG SUPPLY	43,026.84	88.78
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	127,633.52	333.74
CT SCAN	217,552.60	73,304.54
PHYSICAL THERAPY	0.00	816.22
EKG/ECG	31,308.77	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	186,643.16	27,784.24
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,436.64	1,459.94
ANESTHESIA	10,075.63	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	275,093.46	171.89
RECOVERY ROOM	25,923.23	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	635.89	1,271.78
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	377.58
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	61,296.71	1,410.81
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,373.68	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,003.38	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,893.32	1,061.10

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	62,928.24	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	66.69
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	333,770.16	83,960.74
MRI SERVICES	78,494.81	5,427.77
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,456.66	17,847.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	40.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,537,322.40	215,423.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,537,322.40	215,423.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	55,629.46	ADJUSTMENTS	0.00
COVERED CHARGES	43,649.40	CONTRACTUAL ALLOW	10,264.90
NON-COVERD CHARGES	11,980.06	TOTAL MEDICAID LIAB	33,384.50
		LESS: COB	33,297.50
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	292.01	0.00
MED/SURG SUPPLY	422.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,280.47	0.00
CT SCAN	1,851.15	5,748.16
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	181.44	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	2,997.48
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	9,579.83	0.00
RECOVERY ROOM	200.48	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,587.25	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,257.57	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,434.78	3,082.98
MRI SERVICES	4,284.80	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	277.22	151.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	43,649.40	11,980.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,649.40	11,980.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,513.16	ADJUSTMENTS	957.29
COVERED CHARGES	79,388.10	CONTRACTUAL ALLOW	69,817.99
NON-COVERD CHARGES	3,125.06	TOTAL MEDICAID LIAB	9,570.11
		LESS: COB	0.00
		LESS: COPAYMENT	357.03
		REIMBURSEMENT	9,213.08

TOTAL NUMBER OF CLAIMS 174

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	201.50	0.00
MED/SURG SUPPLY	185.73	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,220.22	0.00
CT SCAN	3,811.59	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,066.36	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	94.20	103.30
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	54,599.57	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 SERVICE	1,085.05	1,032.53
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,824.50	1,833.83
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,299.38	155.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	79,388.10	3,125.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,388.10	3,125.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,548.83	ADJUSTMENTS	0.00
COVERED CHARGES	6,028.14	CONTRACTUAL ALLOW	1,359.41
NON-COVERD CHARGES	2,520.69	TOTAL MEDICAID LIAB	4,668.73
		LESS: COB	4,653.73
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	446.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,851.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,048.30	392.13
EKG/ECG	181.44	181.44	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	188.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,941.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.28	36.57
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,028.14	2,520.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,028.14	2,520.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,862.34	ADJUSTMENTS	4,767.64
COVERED CHARGES	17,740.30	CONTRACTUAL ALLOW	12,966.66
NON-COVERD CHARGES	122.04	TOTAL MEDICAID LIAB	4,773.64
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	4,767.64

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,335.76	0.00
MED/SURG SUPPLY	6,759.83	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320.29	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	6,444.93	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,292.95	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,295.90	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	196.44	10.85
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	94.20	111.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,740.30	122.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,740.30	122.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,157,221.94	ADJUSTMENTS	4,419,936.07
COVERED CHARGES	66,605,640.59	CONTRACTUAL ALLOW	45,827,328.96
NON-COVERD CHARGES	2,551,581.35	TOTAL MEDICAID LIAB	20,778,311.63
		LESS: COB	43,671.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,734,640.31

TOTAL NUMBER OF ADMISSIONS 2,256

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,290	7	4,918,560.00	1,009,184.34
ROUTINE NURSERY	1,578	0	543,794.00	500.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	0.00
TOTAL ROUTINE	11,868	8	5,462,354.00	1,009,684.34
SPECIAL CARE SERVICES				
CCU	527	0	672,306.66	0.00
ICU	1,257	0	1,654,222.00	0.00
NICU	987	0	1,260,121.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	456	0.00	232,131.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,771	456	3,586,649.66	232,131.00
TOTAL ACCOMODATIONS	14,639	464	9,049,003.66	1,241,815.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,555,796.90	56,812.11
MED/SURG SUPPLY	7,406,053.31	129,827.84
LABORATORY-GENERAL	6,850,785.65	27,226.71
RADIOLOGY-DIAGNOSTIC	1,472,844.42	3,678.32
CT SCAN	1,295,667.00	480,784.68
PHYSICAL THERAPY	569,937.31	5,276.91
EKG/ECG	282,066.07	186.43
IV THERAPY	273,942.47	3,163.86
OPERATING ROOM	4,800,090.81	14,860.40
LABOR/DELIVERY ROOM	257,661.43	0.00
RESPIRATORY SERVICES	2,233,478.58	4,070.68
ANESTHESIA	409,871.96	431.47
GI SERVICES	343,985.77	2,950.34
EMERGENCY ROOM	1,721,268.87	11,976.08
RECOVERY ROOM	676,321.21	841.27
LABORATORY PATHOLOGIC	229,933.94	772.00
RADIOLOGY THERAPEUTIC	549,184.99	0.00
OCCUPATIONAL THERAPY	292,379.34	4,362.32
SPEECH PATHOLOGY	122,400.91	0.00
RENAL DIALYSIS	145,708.71	88,876.23
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	60.32	48,477.57
PSYCHIATRIC SERVICES	1,665.00	0.00
LITHOTRIPSY	33,436.50	0.00
OTHER IMAGING SERVICE	343,806.79	4,250.00
BLOOD	5,110.00	0.00
BLOOD STORAGE & PRO.	2,175,857.19	179,008.12
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	179,787.57	0.00
AUDIOLOGY	39,545.24	0.00
CARDIOLOGY	2,089,776.24	1,909.84
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	46,694.19	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,124,498.81	157,526.37

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	382,901.82	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,800.20	0.00
OTHER THERAPEUTIC SVC	0.00	27,138.29
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	464,685.26	6,702.94
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	14,964.40	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,161,667.75	44,312.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,342.44

TOTAL ANCILLARY	57,556,636.93	1,309,766.01
TOTAL ACCOMODATIONS	9,049,003.66	1,241,815.34
TOTAL CHARGES	66,605,640.59	2,551,581.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2212025001320	05/31/11 - 06/24/11	01/30/12	0.00	2,171.22	0.00	0.00	0.00
615	2212123009806	04/09/11 - 04/15/11	05/07/12	0.00	2,171.22	0.00	0.00	0.00
TOTAL				0.00	4,342.44	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	550,723.55	ADJUSTMENTS	0.00
COVERED CHARGES	531,352.78	CONTRACTUAL ALLOW	254,234.60
NON-COVERD CHARGES	19,370.77	TOTAL MEDICAID LIAB	277,118.18
		LESS: COB	277,118.18
		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	68	0	31,900.00	9,847.00
ROUTINE NURSERY	8	0	4,240.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	76	0	36,140.00	9,847.00
SPECIAL CARE SERVICES				
CCU	6	0	7,920.00	0.00
ICU	4	0	5,280.00	0.00
NICU	47	0	62,015.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	57	0	75,215.00	0.00
TOTAL ACCOMODATIONS	133	0	111,355.00	9,847.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,514.13	0.00
MED/SURG SUPPLY	53,251.60	315.12
LABORATORY-GENERAL	69,151.20	0.00
RADIOLOGY-DIAGNOSTIC	16,373.54	0.00
CT SCAN	12,499.42	3,234.50
PHYSICAL THERAPY	3,232.99	0.00
EKG/ECG	1,305.01	0.00
IV THERAPY	131.51	0.00
OPERATING ROOM	25,410.79	0.00
LABOR/DELIVERY ROOM	3,371.63	0.00
RESPIRATORY SERVICES	36,068.25	0.00
ANESTHESIA	2,130.44	0.00
GI SERVICES	2,950.34	0.00
EMERGENCY ROOM	6,082.51	0.00
RECOVERY ROOM	3,800.99	0.00
LABORATORY PATHOLOGIC	1,498.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	660.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,505.26	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,953.88	4,487.35
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,073.08	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,610.84	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,441.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	826.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,640.67	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	419,997.78	9,523.77
TOTAL ACCOMODATIONS	111,355.00	9,847.00
TOTAL CHARGES	531,352.78	19,370.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,958,816.90	ADJUSTMENTS	979,247.73
COVERED CHARGES	31,855,247.55	CONTRACTUAL ALLOW	24,304,529.22
NON-COVERD CHARGES	5,103,569.35	TOTAL MEDICAID LIAB	7,550,718.33
		LESS: COB	2,282.05
		LESS: COPAYMENT	37,787.78
		REIMBURSEMENT	7,510,648.50
		ALL OTHER	6,150,127.65
		FEE SCHEDULE-LAB	500,621.98
		INJECTABLE DRUGS	859,898.87

TOTAL NUMBER OF CLAIMS 15,975

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,460,112.92	28,787.82
MED/SURG SUPPLY	2,226,172.47	71,307.14
LABORATORY-GENERAL	0.00	2,097.64
RADIOLOGY-DIAGNOSTIC	1,000,142.53	41,618.53
CT SCAN	1,775,167.24	211,670.37
PHYSICAL THERAPY	78,743.00	20,315.00
EKG/ECG	230,267.30	18,707.54
IV THERAPY	762,034.34	5,580.61
OPERATING ROOM	2,068,499.34	520,268.94
LABOR/DELIVERY ROOM	150,278.04	0.00
RESPIRATORY SERVICES	226,971.30	114,644.38
ANESTHESIA	250,842.41	340.00
GI SERVICES	410,514.39	44,746.02
EMERGENCY ROOM	3,574,617.84	45,804.65
RECOVERY ROOM	636,803.83	3,225.96
LABORATORY PATHOLOGIC	0.00	468.00
RADIOLOGY THERAPEUTIC	2,540,834.26	19,015.13
OCCUPATIONAL THERAPY	8,175.00	2,569.61
SPEECH PATHOLOGY	6,883.00	15,202.43
RENAL DIALYSIS	0.00	796.23
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,153,374.69	298,790.61
PSYCHIATRIC SERVICES	234,395.00	925.00
LITHOTRIPSY	16,718.25	0.00
OTHER IMAGING SERVICE	994,241.29	71,475.51
BLOOD	1.00	0.00
BLOOD STORAGE & PRO.	331,621.47	197,443.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	670,449.59	21,131.95
AUDIOLOGY	30,234.77	31,590.14
CARDIOLOGY	512,926.78	231,455.68
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	396,246.09	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	327,642.56	361.69

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	233,221.14	22,146.93
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,093.86	215.40
OTHER THERAPEUTIC SVC	16,326.68	3,564.21
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,734,358.45	443,564.76
MRI SERVICES	532,914.56	42,277.72
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	510.15	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	666.75
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,261,912.01	2,570,191.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	602.58

TOTAL ANCILLARY	31,855,247.55	5,103,569.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,855,247.55	5,103,569.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	4410259159472	08/24/10 - 08/24/10	09/27/10	0.00	98.00	0.00	0.00	0.00
-1	1110319019648	09/23/10 - 09/23/10	12/27/10	0.00	73.00	0.00	0.00	0.00
59	5211047003687	09/30/10 - 09/30/10	03/07/11	0.00	198.95	0.00	0.00	0.00
8670	2211123006415	01/04/11 - 01/04/11	05/09/11	0.00	67.00	0.00	0.00	0.00
9921	5911236001059	05/16/11 - 05/16/11	08/29/11	0.00	165.63	0.00	0.00	0.00
TOTAL				0.00	602.58	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	290,890.10	ADJUSTMENTS	0.00
COVERED CHARGES	226,671.59	CONTRACTUAL ALLOW	79,962.11
NON-COVERD CHARGES	64,218.51	TOTAL MEDICAID LIAB	146,709.48
		LESS: COB	146,464.41
		LESS: COPAYMENT	245.07
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	137

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,913.75	871.90
MED/SURG SUPPLY	24,213.15	0.00
LABORATORY-GENERAL	0.00	117.00
RADIOLOGY-DIAGNOSTIC	11,537.98	8,212.80
CT SCAN	10,766.90	10,644.54
PHYSICAL THERAPY	0.00	1,195.00
EKG/ECG	2,796.45	186.43
IV THERAPY	2,032.29	0.00
OPERATING ROOM	20,656.89	22,451.95
LABOR/DELIVERY ROOM	2,984.24	0.00
RESPIRATORY SERVICES	251.94	0.00
ANESTHESIA	4,439.41	0.00
GI SERVICES	5,900.68	0.00
EMERGENCY ROOM	34,074.63	572.41
RECOVERY ROOM	10,489.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,332.21	0.00
OCCUPATIONAL THERAPY	0.00	441.00
SPEECH PATHOLOGY	0.00	525.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,896.86	2,394.15
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,583.45	7,029.76
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,523.00	1,794.94
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,273.15	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,323.08	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,189.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,409.87	608.59
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	644.87	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,490.94	3,658.28
MRI SERVICES	1,820.79	2,718.61
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,125.76	796.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	226,671.59	64,218.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	226,671.59	64,218.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,232,083.62	ADJUSTMENTS	5,975.34
COVERED CHARGES	1,172,954.80	CONTRACTUAL ALLOW	1,111,308.92
NON-COVERD CHARGES	59,128.82	TOTAL MEDICAID LIAB	61,645.88
		LESS: COB	0.00
		LESS: COPAYMENT	2,259.01
		REIMBURSEMENT	59,386.87

TOTAL NUMBER OF CLAIMS 1,102

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,193.86	727.44
MED/SURG SUPPLY	38,993.63	143.19
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,302.01	867.51
CT SCAN	51,943.92	9,224.09
PHYSICAL THERAPY	0.00	1,749.00
EKG/ECG	11,185.80	0.00
IV THERAPY	13,472.91	0.00
OPERATING ROOM	9,300.00	946.51
LABOR/DELIVERY ROOM	426.32	0.00
RESPIRATORY SERVICES	2,099.50	680.88
ANESTHESIA	1,020.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	701,781.73	5,118.30
RECOVERY ROOM	3,300.00	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	478.81	183.84
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	24,079.65	1,129.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,344.00	897.47
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,734.49	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,482.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	136,127.00	19,720.70
MRI SERVICES	1,771.85	2,718.61
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,916.80	15,022.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,172,954.80	59,128.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,172,954.80	59,128.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,047.44	ADJUSTMENTS	0.00
COVERED CHARGES	14,395.72	CONTRACTUAL ALLOW	7,244.96
NON-COVERD CHARGES	2,651.72	TOTAL MEDICAID LIAB	7,150.76
		LESS: COB	7,138.76
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
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PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	701.22	0.00
MED/SURG SUPPLY	497.93	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,889.81	0.00
CT SCAN	0.00	1,384.47
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	186.43	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	7,264.50	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,257.00	897.47
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	62.23	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,399.00	321.28
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	137.60	48.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,395.72	2,651.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,395.72	2,651.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,766,095.63	ADJUSTMENTS	215,414.43
COVERED CHARGES	6,416,005.88	CONTRACTUAL ALLOW	5,448,190.24
NON-COVERD CHARGES	350,089.75	TOTAL MEDICAID LIAB	967,815.64
		LESS: COB	0.00
		LESS: COPAYMENT	1,224.00
		REIMBURSEMENT	966,591.64

TOTAL NUMBER OF CLAIMS 181

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,552.48	1,144.08
MED/SURG SUPPLY	928,537.50	1,197.28
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,640.66	23,893.36
CT SCAN	20,276.48	2,713.02
PHYSICAL THERAPY	0.00	466.50
EKG/ECG	13,739.39	745.72
IV THERAPY	112,167.29	580.72
OPERATING ROOM	350,791.27	18,567.36
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,206.76	0.00
ANESTHESIA	33,258.63	0.00
GI SERVICES	2,950.34	0.00
EMERGENCY ROOM	16,338.50	330.72
RECOVERY ROOM	50,387.43	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	335,261.18	2,969.80
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	27,949.03	2,761.83
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	83,591.25	0.00
OTHER IMAGING SERVICE	6,671.32	1,183.32
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,053.00	10,769.64
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,325.08	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	477,800.69	198,527.83
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,560.96	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,947.23	1,194.23

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,946.21	625.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,532.54	267.41
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	61,709.47	11,836.26
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,460,811.19	70,315.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,416,005.88	350,089.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,416,005.88	350,089.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	144,095.77	ADJUSTMENTS	0.00
COVERED CHARGES	143,160.45	CONTRACTUAL ALLOW	90,380.89
NON-COVERD CHARGES	935.32	TOTAL MEDICAID LIAB	52,779.56
		LESS: COB	52,731.56
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
PO BOX 1828
ALBANY,GA 31702-1828

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,117.94	0.00
MED/SURG SUPPLY	5,039.21	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,177.40	303.06
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	186.43	0.00
IV THERAPY	6,990.28	0.00
OPERATING ROOM	10,635.11	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	126.47	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	940.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,968.58	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,341.36	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,081.27	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	588.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	165.36
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,928.00	19.82
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36,040.40	447.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	143,160.45	935.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	143,160.45	935.32

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,937,144.74	ADJUSTMENTS	238,775.11
COVERED CHARGES	5,887,377.74	CONTRACTUAL ALLOW	4,203,950.39
NON-COVERD CHARGES	49,767.00	TOTAL MEDICAID LIAB	1,683,427.35
		LESS: COB	6,814.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,676,613.10

TOTAL NUMBER OF ADMISSIONS 228

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	863	8	703,345.00	35,975.00
ROUTINE NURSERY	36	0	20,718.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	899	8	724,063.00	35,975.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	159	0	333,780.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	159	0	333,780.00	0.00
TOTAL ACCOMODATIONS	1,058	8	1,057,843.00	35,975.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,327,918.80	0.00
MED/SURG SUPPLY	180,689.54	308.00
LABORATORY-GENERAL	861,741.00	0.00
RADIOLOGY-DIAGNOSTIC	133,212.00	0.00
CT SCAN	370,581.00	4,763.00
PHYSICAL THERAPY	17,511.00	0.00
EKG/ECG	52,180.00	0.00
IV THERAPY	20,842.00	0.00
OPERATING ROOM	446,939.00	1,971.00
LABOR/DELIVERY ROOM	96,698.00	0.00
RESPIRATORY SERVICES	322,302.00	0.00
ANESTHESIA	70,965.00	0.00
GI SERVICES	30,507.00	0.00
EMERGENCY ROOM	327,517.00	1,348.00
RECOVERY ROOM	81,851.00	0.00
LABORATORY PATHOLOGIC	76.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,618.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,058.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	42,532.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	123,275.00	2,613.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,182.00	2,537.00
AUDIOLOGY	4,244.00	0.00
CARDIOLOGY	113,295.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,608.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	23,047.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	33,934.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	105,475.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,736.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	252.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,829,534.74	13,792.00
TOTAL ACCOMODATIONS	1,057,843.00	35,975.00
TOTAL CHARGES	5,887,377.74	49,767.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,061.60	ADJUSTMENTS	0.00
COVERED CHARGES	31,036.60	CONTRACTUAL ALLOW	7,758.24
NON-COVERD CHARGES	25.00	TOTAL MEDICAID LIAB	23,278.36
		LESS: COB	23,278.36
		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	1	0	815.00	25.00
ROUTINE NURSERY	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	815.00	25.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	6,195.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	6,195.00	0.00
TOTAL ACCOMODATIONS	4	0	7,010.00	25.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,462.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	728.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,695.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,176.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,336.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	310.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	297.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,922.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,026.60	0.00
TOTAL ACCOMODATIONS	7,010.00	25.00
TOTAL CHARGES	31,036.60	25.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,989,399.84	ADJUSTMENTS	372,866.56
COVERED CHARGES	6,212,076.80	CONTRACTUAL ALLOW	4,973,443.32
NON-COVERD CHARGES	777,323.04	TOTAL MEDICAID LIAB	1,238,633.48
		LESS: COB	612.58
		LESS: COPAYMENT	3,207.00
		REIMBURSEMENT	1,234,813.90
		ALL OTHER	1,137,245.03
		FEE SCHEDULE-LAB	86,111.31
		INJECTABLE DRUGS	11,457.56

TOTAL NUMBER OF CLAIMS 2,558

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,821.00	7,006.80
MED/SURG SUPPLY	147,256.18	400.00
LABORATORY-GENERAL	0.00	211.00
RADIOLOGY-DIAGNOSTIC	322,911.00	8,219.00
CT SCAN	1,181,610.00	211,706.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	76,100.00	0.00
IV THERAPY	18,688.00	0.00
OPERATING ROOM	478,151.75	126,443.25
LABOR/DELIVERY ROOM	46,490.00	0.00
RESPIRATORY SERVICES	24,609.00	1,119.00
ANESTHESIA	60,750.00	15,266.00
GI SERVICES	110,349.00	39,094.00
EMERGENCY ROOM	993,598.00	30,231.00
RECOVERY ROOM	118,641.00	1,737.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,138.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,013.00	1,187.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	138,089.00	12,890.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,812.00	3,945.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	223,824.00	28,020.00
AUDIOLOGY	179.00	0.00
CARDIOLOGY	222,957.00	41,772.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	157,719.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	110,986.00	20,122.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	72,966.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,043,837.37	159,854.70
MRI SERVICES	348,203.00	25,439.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	53,378.50	42,518.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	84.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,212,076.80	777,265.54
TOTAL ACCOMODATIONS	0.00	57.50
TOTAL CHARGES	6,212,076.80	777,323.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	157,997.35	ADJUSTMENTS	0.00
COVERED CHARGES	124,365.35	CONTRACTUAL ALLOW	77,006.39
NON-COVERD CHARGES	33,632.00	TOTAL MEDICAID LIAB	47,358.96
		LESS: COB	47,280.96
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,628.75	0.00
MED/SURG SUPPLY	4,370.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,764.00	0.00
CT SCAN	6,815.00	5,596.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	938.00	0.00
IV THERAPY	468.00	0.00
OPERATING ROOM	24,715.00	14,189.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	660.00	90.00
ANESTHESIA	5,199.00	0.00
GI SERVICES	673.00	3,976.00
EMERGENCY ROOM	17,318.00	0.00
RECOVERY ROOM	10,380.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	275.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,973.00	916.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,616.00	740.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,911.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	712.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,133.00	2,238.00
MRI SERVICES	10,654.00	4,122.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	162.00	1,411.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	354.00

TOTAL ANCILLARY	124,365.35	33,632.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	124,365.35	33,632.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3050	4010263000295	08/09/10 - 08/09/10	09/27/10	0.00	148.00	0.00	876.24	0.00
4501	4010263000295	08/09/10 - 08/09/10	09/27/10	0.00	206.00	0.00	876.24	0.00
TOTAL				0.00	354.00	0.00	1,752.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	331,897.75	ADJUSTMENTS	2,732.94
COVERED CHARGES	318,441.65	CONTRACTUAL ALLOW	303,897.25
NON-COVERD CHARGES	13,456.10	TOTAL MEDICAID LIAB	14,544.40
		LESS: COB	20.26
		LESS: COPAYMENT	510.03
		REIMBURSEMENT	14,014.11

TOTAL NUMBER OF CLAIMS 260

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,382.10	0.00
MED/SURG SUPPLY	619.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,317.00	0.00
CT SCAN	25,470.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,148.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,748.00	90.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	169,086.00	3,193.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,876.00	916.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	847.95	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	61,306.00	5,661.00
MRI SERVICES	10,714.00	3,347.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	927.00	249.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	318,441.65	13,456.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	318,441.65	13,456.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,589.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,243.00	CONTRACTUAL ALLOW	7,675.18
NON-COVERD CHARGES	346.00	TOTAL MEDICAID LIAB	3,567.82
		LESS: COB	3,555.82
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	675.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	510.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,620.00	135.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,384.00	211.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,243.00	346.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,243.00	346.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	292,780.37	ADJUSTMENTS	10,174.18
COVERED CHARGES	268,292.37	CONTRACTUAL ALLOW	218,090.01
NON-COVERD CHARGES	24,488.00	TOTAL MEDICAID LIAB	50,202.36
		LESS: COB	0.00
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	50,136.36

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,443.45	0.00
MED/SURG SUPPLY	55,165.02	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,747.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	348.00
EKG/ECG	2,202.00	0.00
IV THERAPY	657.00	0.00
OPERATING ROOM	137,744.00	9,161.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	367.00	0.00
ANESTHESIA	10,606.00	12,437.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,857.00	422.00
RECOVERY ROOM	17,160.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	651.00	916.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,998.90	418.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,922.00	258.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	772.00	528.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	268,292.37	24,488.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	268,292.37	24,488.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
2001 PEACHTREE RD NE STE 400
ATLANTA,GA 30309-1476

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,765,397.52	ADJUSTMENTS	4,041,838.66
COVERED CHARGES	48,194,167.32	CONTRACTUAL ALLOW	36,129,321.09
NON-COVERD CHARGES	571,230.20	TOTAL MEDICAID LIAB	12,064,846.23
		LESS: COB	219,471.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,845,374.57

TOTAL NUMBER OF ADMISSIONS 719

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,024	4	3,360,040.00	210,607.00
ROUTINE NURSERY	292	0	400,475.00	23,400.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,316	4	3,760,515.00	234,007.00
SPECIAL CARE SERVICES				
CCU	211	0	469,199.00	0.00
ICU	1,049	0	2,370,802.00	0.00
NICU	547	0	1,255,935.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,807	0	4,095,936.00	0.00
TOTAL ACCOMODATIONS	6,123	4	7,856,451.00	234,007.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,732,793.14	11,716.20
MED/SURG SUPPLY	4,064,695.19	89,373.00
LABORATORY-GENERAL	6,468,114.80	12,465.00
RADIOLOGY-DIAGNOSTIC	1,483,531.00	380.00
CT SCAN	1,656,456.00	3,070.00
PHYSICAL THERAPY	296,309.00	0.00
EKG/ECG	214,929.00	250.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,651,944.50	0.00
LABOR/DELIVERY ROOM	74,625.00	0.00
RESPIRATORY SERVICES	2,308,602.00	876.00
ANESTHESIA	526,638.00	2,060.00
GI SERVICES	379,477.00	0.00
EMERGENCY ROOM	808,586.00	10,655.00
RECOVERY ROOM	413,488.00	2,840.00
LABORATORY PATHOLOGIC	185,385.00	410.00
RADIOLOGY THERAPEUTIC	59,030.00	0.00
OCCUPATIONAL THERAPY	134,344.00	0.00
SPEECH PATHOLOGY	79,272.10	1,168.00
RENAL DIALYSIS	771,896.00	128,101.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	11,559.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	287,169.00	14,576.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,054,624.50	17,668.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	230,368.00	29,845.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,739,301.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,491.00	0.00
ORGAN ACQUISITION	535,402.00	0.00
TREATMENT/OBSERV. RM	66,944.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	319,180.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	628,489.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	134,631.39	211.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	40,337,716.32	337,223.20
TOTAL ACCOMODATIONS	7,856,451.00	234,007.00
TOTAL CHARGES	48,194,167.32	571,230.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,048,020.22	ADJUSTMENTS	0.00
COVERED CHARGES	1,042,331.22	CONTRACTUAL ALLOW	463,364.89
NON-COVERD CHARGES	5,689.00	TOTAL MEDICAID LIAB	578,966.33
		LESS: COB	578,966.33
		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	55	0	45,925.00	3,134.00
ROUTINE NURSERY	66	0	101,060.00	2,555.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	121	0	146,985.00	5,689.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	111	0	250,860.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	111	0	250,860.00	0.00
TOTAL ACCOMODATIONS	232	0	397,845.00	5,689.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,363.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,042.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	168,104.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,958.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,740.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,917.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,726.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,829.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,398.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,569.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,942.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,435.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,031.00	0.00	INJECTABLE DRUGS	790.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	11,497.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,254.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,640.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	644,486.22	0.00
TOTAL ACCOMODATIONS	397,845.00	5,689.00
TOTAL CHARGES	1,042,331.22	5,689.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,589,956.52	ADJUSTMENTS	477,958.29
COVERED CHARGES	8,612,478.01	CONTRACTUAL ALLOW	6,789,855.95
NON-COVERD CHARGES	1,977,478.51	TOTAL MEDICAID LIAB	1,822,622.06
		LESS: COB	26,018.15
		LESS: COPAYMENT	4,719.04
		REIMBURSEMENT	1,791,884.87
		ALL OTHER	1,552,825.98
		FEE SCHEDULE-LAB	159,123.63
		INJECTABLE DRUGS	79,935.26

TOTAL NUMBER OF CLAIMS 3,144

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	360,421.26	73,382.66
MED/SURG SUPPLY	345,373.21	120,880.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	500,808.00	30,262.00
CT SCAN	771,246.00	255,985.00
PHYSICAL THERAPY	2,570.00	6,244.00
EKG/ECG	119,438.00	1,000.00
IV THERAPY	16,149.00	519.00
OPERATING ROOM	608,167.00	210,525.00
LABOR/DELIVERY ROOM	11,776.00	0.00
RESPIRATORY SERVICES	56,504.00	21,870.00
ANESTHESIA	86,352.00	27,756.00
GI SERVICES	124,047.00	69,318.00
EMERGENCY ROOM	1,051,246.00	50,839.00
RECOVERY ROOM	189,708.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	66,944.00	65,072.00
OCCUPATIONAL THERAPY	540.00	2,950.00
SPEECH PATHOLOGY	2,316.00	1,415.00
RENAL DIALYSIS	0.00	33,703.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	105,806.00	6,819.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	306,775.00	37,620.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24,325.00	5,110.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	350,619.00	65,616.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	688,793.00	199,891.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,891.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	178,996.34	2,813.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	107,291.00	1,131.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	824.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,779,873.60	441,686.10
MRI SERVICES	328,570.00	31,495.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	358,108.60	212,729.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	692.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	155.00

TOTAL ANCILLARY	8,612,478.01	1,977,478.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,612,478.01	1,977,478.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
245	4410259117211	07/26/10 - 07/26/10	09/27/10	0.00	155.00	0.00	0.00	0.00
TOTAL				0.00	155.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	427,913.91	ADJUSTMENTS	0.00
COVERED CHARGES	249,991.16	CONTRACTUAL ALLOW	121,588.87
NON-COVERD CHARGES	177,922.75	TOTAL MEDICAID LIAB	128,402.29
		LESS: COB	128,210.29
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,698.50	156.00
MED/SURG SUPPLY	30,057.25	482.00
LABORATORY-GENERAL	0.00	2,664.00
RADIOLOGY-DIAGNOSTIC	10,600.00	341.00
CT SCAN	6,598.00	29,124.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,470.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,464.00	36,671.00
LABOR/DELIVERY ROOM	2,578.00	0.00
RESPIRATORY SERVICES	1,982.00	0.00
ANESTHESIA	5,653.00	2,893.00
GI SERVICES	8,328.00	12,275.00
EMERGENCY ROOM	20,941.00	1,085.00
RECOVERY ROOM	11,857.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,391.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,014.00	165.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,107.00	687.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,396.00	647.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,007.00	11,617.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,009.41	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,433.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	49,442.00	24,817.00
MRI SERVICES	8,960.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,005.00	51,613.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	249,991.16	175,237.75
TOTAL ACCOMODATIONS	0.00	2,685.00
TOTAL CHARGES	249,991.16	177,922.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,447.90	ADJUSTMENTS	2,232.48
COVERED CHARGES	177,257.50	CONTRACTUAL ALLOW	165,286.34
NON-COVERD CHARGES	6,190.40	TOTAL MEDICAID LIAB	11,971.16
		LESS: COB	0.00
		LESS: COPAYMENT	534.01
		REIMBURSEMENT	11,437.15

TOTAL NUMBER OF CLAIMS 214

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,533.00	0.00	OTHER LAB	1,466.00	0.00
MED/SURG SUPPLY	225.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,383.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,238.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,138.00	2,576.00
EKG/ECG	2,952.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	824.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	742.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,264.00	1,572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,407.00	62.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,085.00	1,980.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,257.50	6,190.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,257.50	6,190.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,380.30	ADJUSTMENTS	0.00
COVERED CHARGES	11,303.10	CONTRACTUAL ALLOW	6,375.66
NON-COVERD CHARGES	3,077.20	TOTAL MEDICAID LIAB	4,927.44
		LESS: COB	4,915.44
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	691.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	155.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,254.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,355.00	2,114.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,825.00	25.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,927.00	657.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	35.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	246.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,303.10	3,077.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,303.10	3,077.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
4501	4010258000198	07/05/10 - 07/05/10	09/27/10	0.00	246.00	0.00	526.40	0.00
TOTAL				0.00	246.00	0.00	526.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,165,905.34	ADJUSTMENTS	208,871.85
COVERED CHARGES	4,437,250.74	CONTRACTUAL ALLOW	3,801,444.50
NON-COVERD CHARGES	728,654.60	TOTAL MEDICAID LIAB	635,806.24
		LESS: COB	9,950.52
		LESS: COPAYMENT	697.51
		REIMBURSEMENT	625,158.21

TOTAL NUMBER OF CLAIMS 113

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,779.02	2,622.00
MED/SURG SUPPLY	1,651,221.50	150,607.00
LABORATORY-GENERAL	0.00	23,912.00
RADIOLOGY-DIAGNOSTIC	165,602.00	19,259.00
CT SCAN	30,276.00	21,818.00
PHYSICAL THERAPY	0.00	2,522.00
EKG/ECG	22,652.00	0.00
IV THERAPY	8,038.00	0.00
OPERATING ROOM	486,687.20	29,265.80
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,212.00	0.00
ANESTHESIA	26,282.00	7,830.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,149.00	0.00
RECOVERY ROOM	77,072.00	0.00
LABORATORY PATHOLOGIC	0.00	370.00
RADIOLOGY THERAPEUTIC	183,341.00	4,625.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	4,102.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	432.00	293.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,450.00	2,088.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,664.00	647.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,285.00	1,227.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	694,883.00	183,715.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,440.50	214.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,067.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	93,127.40	49,511.40
MRI SERVICES	22,070.00	4,720.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	808,520.12	195,141.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,437,250.74	704,489.60
TOTAL ACCOMODATIONS	0.00	24,165.00
TOTAL CHARGES	4,437,250.74	728,654.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,972.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,057.00	CONTRACTUAL ALLOW	-1,930.56
NON-COVERD CHARGES	17,915.00	TOTAL MEDICAID LIAB	34,987.56
		LESS: COB	34,987.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
PO BOX 102602
ATLANTA,GA 30368-2602

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,438.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28,811.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	371.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,193.00	475.00
EKG/ECG	244.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	33.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	17,407.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	33,057.00	17,915.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,057.00	17,915.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	444,615.14	ADJUSTMENTS	0.00
COVERED CHARGES	438,133.52	CONTRACTUAL ALLOW	227,974.29
NON-COVERD CHARGES	6,481.62	TOTAL MEDICAID LIAB	210,159.23
		LESS: COB	2,802.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	207,357.21

TOTAL NUMBER OF ADMISSIONS 45

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	130	0	43,420.00	5,736.00
ROUTINE NURSERY	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	130	0	43,420.00	5,736.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	130	0	43,420.00	5,736.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,971.57	0.00
MED/SURG SUPPLY	26,851.00	0.00
LABORATORY-GENERAL	99,725.00	0.00
RADIOLOGY-DIAGNOSTIC	13,781.00	0.00
CT SCAN	41,289.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,190.00	0.00
IV THERAPY	300.00	0.00
OPERATING ROOM	6,760.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,058.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	85,415.00	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	322.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,466.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,545.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,372.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,421.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	304.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47,646.95	441.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	394,713.52	745.62
TOTAL ACCOMODATIONS	43,420.00	5,736.00
TOTAL CHARGES	438,133.52	6,481.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES	00/00/00	THROUGH 00/00/00
SERVICE DATES	10/01/10	THROUGH 09/30/11
ADMISSION DATES	00/00/00	THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,762,713.00	ADJUSTMENTS	21,970.28
COVERED CHARGES	4,070,205.06	CONTRACTUAL ALLOW	3,361,820.63
NON-COVERD CHARGES	692,507.94	TOTAL MEDICAID LIAB	708,384.43
		LESS: COB	77.93
		LESS: COPAYMENT	2,517.00
		REIMBURSEMENT	705,789.50
		ALL OTHER	624,998.02
		FEE SCHEDULE-LAB	78,332.91
		INJECTABLE DRUGS	2,458.57

TOTAL NUMBER OF CLAIMS 3,079

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,093.52	0.00
MED/SURG SUPPLY	43,669.00	104.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	372,286.00	3,048.00
CT SCAN	475,112.00	55,697.00
PHYSICAL THERAPY	31,309.00	16,484.00
EKG/ECG	38,599.00	0.00
IV THERAPY	36,072.00	304.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,452.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,310,247.00	9,002.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,208.00	1,809.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,046.00	3,014.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	63,989.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,266.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,141.00	17,719.80
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,058.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,538.00	152.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,072.00	3,455.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,546,734.48	557,666.50
MRI SERVICES	13,252.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,061.06	24,052.64
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,070,205.06	692,507.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,070,205.06	692,507.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,705.49	ADJUSTMENTS	0.00
COVERED CHARGES	21,543.49	CONTRACTUAL ALLOW	13,130.35
NON-COVERD CHARGES	1,162.00	TOTAL MEDICAID LIAB	8,413.14
		LESS: COB	8,410.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660.53	0.00
MED/SURG SUPPLY	289.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,229.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	638.00	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	9,984.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,917.00	1,162.00
MRI SERVICES	3,361.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	464.96	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,543.49	1,162.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,543.49	1,162.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	517,420.74	ADJUSTMENTS	732.00
COVERED CHARGES	488,423.31	CONTRACTUAL ALLOW	459,523.31
NON-COVERD CHARGES	28,997.43	TOTAL MEDICAID LIAB	28,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,092.04
		REIMBURSEMENT	27,807.96

TOTAL NUMBER OF CLAIMS 578

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,933.91	0.00
MED/SURG SUPPLY	3,063.00	421.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,832.00	339.00
CT SCAN	23,473.00	3,264.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,914.00	0.00
IV THERAPY	530.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,508.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	330,695.00	152.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	80,390.00	22,659.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,084.40	2,162.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	488,423.31	28,997.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	488,423.31	28,997.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,286.94	ADJUSTMENTS	0.00
COVERED CHARGES	5,194.94	CONTRACTUAL ALLOW	1,785.73
NON-COVERD CHARGES	92.00	TOTAL MEDICAID LIAB	3,409.21
		LESS: COB	3,400.21
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	424.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,053.00	92.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,716.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,194.94	92.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,194.94	92.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	462,291.65	ADJUSTMENTS	43,533.61
COVERED CHARGES	452,523.73	CONTRACTUAL ALLOW	142,461.63
NON-COVERD CHARGES	9,767.92	TOTAL MEDICAID LIAB	310,062.10
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	310,062.10

TOTAL NUMBER OF ADMISSIONS 66

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	167	0	54,275.00	2,775.00
ROUTINE NURSERY	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	167	0	54,275.00	2,775.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	24	0	14,450.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	14,450.00	0.00
TOTAL ACCOMODATIONS	191	0	68,725.00	2,775.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,701.12	0.00
MED/SURG SUPPLY	30,773.31	0.00
LABORATORY-GENERAL	79,640.79	0.00
RADIOLOGY-DIAGNOSTIC	12,058.00	0.00
CT SCAN	41,807.46	6,992.92
PHYSICAL THERAPY	758.84	0.00
EKG/ECG	12,749.94	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,336.31	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,365.54	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	2,906.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,460.44	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,074.44	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,686.97	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/OBSERV. RM	1,391.51	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,427.76	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	20,536.39	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,123.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	383,798.73	6,992.92
TOTAL ACCOMODATIONS	68,725.00	2,775.00
TOTAL CHARGES	452,523.73	9,767.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/10	THROUGH	09/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	898,891.34	ADJUSTMENTS	93,279.72
COVERED CHARGES	797,672.62	CONTRACTUAL ALLOW	415,158.32
NON-COVERD CHARGES	101,218.72	TOTAL MEDICAID LIAB	382,514.30
		LESS: COB	245.80
		LESS: COPAYMENT	675.00
		REIMBURSEMENT	381,593.50
		ALL OTHER	343,869.69
		FEE SCHEDULE-LAB	28,766.11
		INJECTABLE DRUGS	8,957.70

TOTAL NUMBER OF CLAIMS 1,030

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,738.77	4,104.90
MED/SURG SUPPLY	32,875.30	1,333.82
LABORATORY-GENERAL	0.00	1,113.85
RADIOLOGY-DIAGNOSTIC	54,282.78	1,990.38
CT SCAN	149,257.62	13,661.44
PHYSICAL THERAPY	1,795.60	411.04
EKG/ECG	22,105.33	594.86
IV THERAPY	0.00	0.00
OPERATING ROOM	15,673.57	2,854.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,398.07	823.28
ANESTHESIA	15,208.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	159,469.38	4,706.46
RECOVERY ROOM	7,110.03	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	344.09	934.42
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,579.47	961.35
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,176.16	1,005.79
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,392.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17,576.11	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,265.31	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	170,304.40	56,572.26
MRI SERVICES	34,957.77	5,283.88
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,162.84	4,768.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	98.56

TOTAL ANCILLARY	797,672.62	101,218.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	797,672.62	101,218.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3300	2211165004813	06/09/11 - 06/09/11	06/20/11	0.00	55.71	0.00	0.00	0.00
9637	2211181007933	05/30/11 - 05/31/11	07/04/11	0.00	42.85	0.00	0.00	0.00
TOTAL				0.00	98.56	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,039.30	ADJUSTMENTS	0.00
COVERED CHARGES	7,467.18	CONTRACTUAL ALLOW	-1,284.43
NON-COVERD CHARGES	6,572.12	TOTAL MEDICAID LIAB	8,751.61
		LESS: COB	8,739.61
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.00	514.40
MED/SURG SUPPLY	301.02	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	462.76	0.00
CT SCAN	1,423.46	3,299.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	144.82	72.41
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	1,677.07
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,024.96	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,180.91	56.78
RECOVERY ROOM	430.03	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,985.22	908.16
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65.00	44.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,467.18	6,572.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,467.18	6,572.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,176.11	ADJUSTMENTS	535.96
COVERED CHARGES	58,175.04	CONTRACTUAL ALLOW	51,300.28
NON-COVERD CHARGES	5,001.07	TOTAL MEDICAID LIAB	6,874.76
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	6,562.76

TOTAL NUMBER OF CLAIMS 155

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,102.00	279.00
MED/SURG SUPPLY	1,220.45	0.00
LABORATORY-GENERAL	0.00	44.56
RADIOLOGY-DIAGNOSTIC	2,939.99	0.00
CT SCAN	12,990.80	915.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	568.73	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	366.73	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,269.04	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 SERVICE	1,568.88	312.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,160.40	2,833.36
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,988.02	510.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	106.95

TOTAL ANCILLARY	58,175.04	5,001.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,175.04	5,001.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3300	2211200009025	07/14/11 - 07/14/11	07/25/11	0.00	106.95	0.00	0.00	0.00
TOTAL				0.00	106.95	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	344.86	ADJUSTMENTS	0.00
COVERED CHARGES	344.86	CONTRACTUAL ALLOW	192.29
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	152.57
		LESS: COB	146.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	320.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	344.86	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	344.86	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,909.67	ADJUSTMENTS	8,973.80
COVERED CHARGES	32,746.61	CONTRACTUAL ALLOW	19,281.41
NON-COVERD CHARGES	4,163.06	TOTAL MEDICAID LIAB	13,465.20
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	13,459.20

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,224.00	0.00	OTHER LAB	594.52	0.00
MED/SURG SUPPLY	5,514.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	222.82	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	942.66	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	988.14	811.35
EKG/ECG	395.49	0.00	MRI SERVICES	4,201.34	1,880.46
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,260.06	1,297.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,400.62	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	538.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,056.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	470.00	132.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	41.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	9,970.73	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	598.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323.89	0.00			

TOTAL ANCILLARY	32,746.61	4,163.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,746.61	4,163.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,621,413.33	ADJUSTMENTS	105,012.55
COVERED CHARGES	1,603,220.07	CONTRACTUAL ALLOW	667,497.57
NON-COVERD CHARGES	18,193.26	TOTAL MEDICAID LIAB	935,722.50
		LESS: COB	9,875.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	925,847.07

TOTAL NUMBER OF ADMISSIONS 191

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	447	0	196,240.00	13,560.00
ROUTINE NURSERY	55	0	22,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	502	0	218,240.00	13,560.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	104	0	115,100.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	104	0	115,100.00	0.00
TOTAL ACCOMODATIONS	606	0	333,340.00	13,560.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	301,667.12	0.00
MED/SURG SUPPLY	111,119.31	44.51
LABORATORY-GENERAL	198,186.00	31.00
RADIOLOGY-DIAGNOSTIC	22,927.00	0.00
CT SCAN	41,404.00	0.00
PHYSICAL THERAPY	10,330.00	0.00
EKG/ECG	17,691.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	115,599.90	0.00
LABOR/DELIVERY ROOM	11,158.50	0.00
RESPIRATORY SERVICES	55,923.00	0.00
ANESTHESIA	30,555.00	0.00
GI SERVICES	17,622.00	0.00
EMERGENCY ROOM	64,833.84	0.00
RECOVERY ROOM	8,942.50	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	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,773.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	962.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,754.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,435.00	2,208.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,740.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,818.40	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	2,349.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	214,278.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,269,880.07	4,633.26
TOTAL ACCOMODATIONS	333,340.00	13,560.00
TOTAL CHARGES	1,603,220.07	18,193.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,927.75	ADJUSTMENTS	0.00
COVERED CHARGES	2,927.75	CONTRACTUAL ALLOW	1,263.75
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,664.00
		LESS: COB	1,664.00
		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	1	0	440.00	0.00
ROUTINE NURSERY	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	440.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	440.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	131.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	648.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	121.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	540.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	611.25	0.00			

TOTAL ANCILLARY	2,487.75	0.00
TOTAL ACCOMODATIONS	440.00	0.00
TOTAL CHARGES	2,927.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,781,892.02	ADJUSTMENTS	93,569.01
COVERED CHARGES	1,585,540.24	CONTRACTUAL ALLOW	1,188,120.08
NON-COVERD CHARGES	196,351.78	TOTAL MEDICAID LIAB	397,420.16
		LESS: COB	1,964.78
		LESS: COPAYMENT	3,030.58
		REIMBURSEMENT	392,424.80
		ALL OTHER	323,091.05
		FEE SCHEDULE-LAB	64,734.77
		INJECTABLE DRUGS	4,598.98

TOTAL NUMBER OF CLAIMS 2,518

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,378.15	304.00
MED/SURG SUPPLY	56,751.35	1,219.62
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,389.50	2,004.00
CT SCAN	127,429.00	15,708.00
PHYSICAL THERAPY	4,700.00	1,325.00
EKG/ECG	23,500.00	1,027.00
IV THERAPY	4,810.00	640.00
OPERATING ROOM	197,213.70	16,558.00
LABOR/DELIVERY ROOM	5,875.00	175.00
RESPIRATORY SERVICES	7,786.00	1,440.00
ANESTHESIA	62,459.00	0.00
GI SERVICES	37,821.20	7,637.40
EMERGENCY ROOM	228,519.89	4,620.38
RECOVERY ROOM	17,688.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	150.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	17,268.00	1,900.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	21,788.80	0.00
OTHER IMAGING SERVICE	49,236.00	2,421.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,443.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,620.00	1,580.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,009.30	396.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,651.25	7,661.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,567.00	880.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	351,230.00	101,394.33
MRI SERVICES	57,122.60	1,158.30
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	162.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	51,576.50	24,697.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,585,540.24	196,351.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,585,540.24	196,351.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,243.17	ADJUSTMENTS	0.00
COVERED CHARGES	20,495.67	CONTRACTUAL ALLOW	9,582.72
NON-COVERD CHARGES	2,747.50	TOTAL MEDICAID LIAB	10,912.95
		LESS: COB	10,912.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,448.50	0.00	OTHER LAB	176.00	0.00
MED/SURG SUPPLY	631.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	51.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,718.00	778.00
EKG/ECG	70.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,820.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,125.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	858.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,333.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	402.00	1,241.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,320.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	850.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,240.00	677.50			

TOTAL ANCILLARY	20,495.67	2,747.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,495.67	2,747.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,441.51	ADJUSTMENTS	2,364.26
COVERED CHARGES	80,495.71	CONTRACTUAL ALLOW	71,305.03
NON-COVERD CHARGES	10,945.80	TOTAL MEDICAID LIAB	9,190.68
		LESS: COB	0.00
		LESS: COPAYMENT	387.00
		REIMBURSEMENT	8,803.68

TOTAL NUMBER OF CLAIMS 198

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,909.42	0.00	OTHER LAB	220.00	0.00
MED/SURG SUPPLY	1,245.48	46.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,342.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,488.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,709.00	6,539.80
EKG/ECG	839.00	70.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,020.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	309.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	838.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	858.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,135.81	445.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,551.00	825.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,957.50	0.00			

TOTAL ANCILLARY	80,495.71	10,945.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,495.71	10,945.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	799.50	ADJUSTMENTS	0.00
COVERED CHARGES	777.00	CONTRACTUAL ALLOW	461.20
NON-COVERD CHARGES	22.50	TOTAL MEDICAID LIAB	315.80
		LESS: COB	312.80
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	8.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	241.00	14.00
EKG/ECG	136.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	777.00	22.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	777.00	22.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONAL HOSPITAL
PO BOX 1297
HAWKINSVILLE,GA 31036-7297

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	217,386.01	ADJUSTMENTS	0.00
COVERED CHARGES	202,314.01	CONTRACTUAL ALLOW	99,416.80
NON-COVERD CHARGES	15,072.00	TOTAL MEDICAID LIAB	102,897.21
		LESS: COB	5,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	97,897.21

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	58	0	20,880.00	2,205.00
ROUTINE NURSERY	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	58	0	20,880.00	2,205.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	58	0	20,880.00	2,205.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,389.44	0.00	OTHER LAB	563.00	0.00
MED/SURG SUPPLY	11,916.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,175.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,684.00	2,339.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	171.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,660.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,151.00	0.00	PROFESSIONAL FEES	0.00	10,528.00
OPERATING ROOM	35,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,381.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,280.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,728.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,255.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,206.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,368.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	828.00	0.00			

TOTAL ANCILLARY	181,434.01	12,867.00
TOTAL ACCOMODATIONS	20,880.00	2,205.00
TOTAL CHARGES	202,314.01	15,072.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	685,973.49	ADJUSTMENTS	5,119.18
COVERED CHARGES	580,022.75	CONTRACTUAL ALLOW	362,408.84
NON-COVERD CHARGES	105,950.74	TOTAL MEDICAID LIAB	217,613.91
		LESS: COB	284.23
		LESS: COPAYMENT	807.00
		REIMBURSEMENT	216,522.68
		ALL OTHER	201,649.02
		FEE SCHEDULE-LAB	14,776.60
		INJECTABLE DRUGS	97.06

TOTAL NUMBER OF CLAIMS 664

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,886.24	2,560.88
MED/SURG SUPPLY	31,154.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,330.18	1,367.00
CT SCAN	61,085.00	56,208.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,310.00	0.00
IV THERAPY	2,587.00	0.00
OPERATING ROOM	78,541.00	21,748.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,695.00	0.00
ANESTHESIA	3,736.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,336.00	306.00
RECOVERY ROOM	4,000.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,520.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,990.00	3,632.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,184.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,365.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,188.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,925.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	119,974.50	19,878.36
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	214.98	250.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	580,022.75	105,950.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	580,022.75	105,950.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,851.14	ADJUSTMENTS	0.00
COVERED CHARGES	5,462.14	CONTRACTUAL ALLOW	3,685.19
NON-COVERD CHARGES	2,389.00	TOTAL MEDICAID LIAB	1,776.95
		LESS: COB	1,771.21
		LESS: COPAYMENT	5.74
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,836.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,339.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	892.00	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	153.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,096.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,462.14	2,389.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,462.14	2,389.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,223.73	ADJUSTMENTS	94.00
COVERED CHARGES	42,005.73	CONTRACTUAL ALLOW	38,955.73
NON-COVERD CHARGES	5,218.00	TOTAL MEDICAID LIAB	3,050.00
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	2,927.00

TOTAL NUMBER OF CLAIMS 61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,749.58	0.00	OTHER LAB	559.00	0.00
MED/SURG SUPPLY	697.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,237.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,146.00	3,360.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,454.95	1,858.00
EKG/ECG	560.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,090.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	330.00	0.00			

TOTAL ANCILLARY	42,005.73	5,218.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,005.73	5,218.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,644.85	ADJUSTMENTS	0.00
COVERED CHARGES	1,619.85	CONTRACTUAL ALLOW	721.25
NON-COVERD CHARGES	25.00	TOTAL MEDICAID LIAB	898.60
		LESS: COB	898.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	537.00	25.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,619.85	25.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,619.85	25.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	92,417.62	ADJUSTMENTS	0.00
COVERED CHARGES	91,976.62	CONTRACTUAL ALLOW	69,160.17
NON-COVERD CHARGES	441.00	TOTAL MEDICAID LIAB	22,816.45
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	22,801.45

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,732.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,369.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.00	441.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,560.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,460.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	137.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,269.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	620.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	338.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	180.00	0.00			

TOTAL ANCILLARY	91,976.62	441.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,976.62	441.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,627,027.19	ADJUSTMENTS	873,624.50
COVERED CHARGES	25,321,179.39	CONTRACTUAL ALLOW	19,066,524.04
NON-COVERD CHARGES	305,847.80	TOTAL MEDICAID LIAB	6,254,655.35
		LESS: COB	39,368.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,215,286.79

TOTAL NUMBER OF ADMISSIONS 561

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,412	0	1,114,304.00	202,933.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	1,048.00
TOTAL ROUTINE	2,412	0	1,114,304.00	203,981.00
SPECIAL CARE SERVICES				
CCU	162	0	228,270.00	0.00
ICU	360	0	541,191.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	522	0	769,461.00	0.00
TOTAL ACCOMODATIONS	2,934	0	1,883,765.00	203,981.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,564,162.69	0.00
MED/SURG SUPPLY	4,084,010.38	571.00
LABORATORY-GENERAL	4,039,731.00	468.00
RADIOLOGY-DIAGNOSTIC	762,901.00	0.00
CT SCAN	1,148,568.00	6,769.00
PHYSICAL THERAPY	344,044.00	0.00
EKG/ECG	256,632.00	0.00
IV THERAPY	52,694.00	0.00
OPERATING ROOM	2,962,205.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,492,770.00	0.00
ANESTHESIA	366,073.00	0.00
GI SERVICES	49,408.00	0.00
EMERGENCY ROOM	789,716.00	0.00
RECOVERY ROOM	222,571.00	0.00
LABORATORY PATHOLOGIC	107,980.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	265,006.00	0.00
SPEECH PATHOLOGY	119,295.00	0.00
RENAL DIALYSIS	67,974.00	31,895.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,795.00	1,426.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	88,110.00	5,144.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	317,585.00	7,544.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	280,583.00	18,831.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,771,339.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,112.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,765.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	142,208.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,138.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	200,754.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,023.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,895,422.32	21,057.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	23,437,414.39	101,866.80
TOTAL ACCOMODATIONS	1,883,765.00	203,981.00
TOTAL CHARGES	25,321,179.39	305,847.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107,674.36	ADJUSTMENTS	0.00
COVERED CHARGES	106,694.36	CONTRACTUAL ALLOW	79,123.12
NON-COVERD CHARGES	980.00	TOTAL MEDICAID LIAB	27,571.24
		LESS: COB	27,571.24
		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	15	0	6,930.00	980.00
ROUTINE NURSERY	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	15	0	6,930.00	980.00
SPECIAL CARE SERVICES				
CCU	2	0	2,840.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	2,840.00	0.00
TOTAL ACCOMODATIONS	17	0	9,770.00	980.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,093.23	0.00	OTHER LAB	2,182.00	0.00
MED/SURG SUPPLY	13,040.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,768.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,938.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	568.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	948.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,414.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,106.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,455.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,701.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,774.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,967.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	179.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,679.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,686.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	96,924.36	0.00
TOTAL ACCOMODATIONS	9,770.00	980.00
TOTAL CHARGES	106,694.36	980.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,866,645.89	ADJUSTMENTS	348,113.02
COVERED CHARGES	11,651,257.69	CONTRACTUAL ALLOW	9,564,577.35
NON-COVERD CHARGES	2,215,388.20	TOTAL MEDICAID LIAB	2,086,680.34
		LESS: COB	1,227.54
		LESS: COPAYMENT	3,654.98
		REIMBURSEMENT	2,081,797.82
		ALL OTHER	1,924,632.54
		FEE SCHEDULE-LAB	117,419.82
		INJECTABLE DRUGS	39,745.46

TOTAL NUMBER OF CLAIMS 3,172

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351,408.45	3,736.53
MED/SURG SUPPLY	811,904.47	159,545.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	888,972.25	29,847.00
CT SCAN	1,410,517.00	185,952.00
PHYSICAL THERAPY	39,387.00	29,139.00
EKG/ECG	257,561.00	350.00
IV THERAPY	223,944.00	608.00
OPERATING ROOM	694,138.45	330,019.90
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40,374.00	17,920.00
ANESTHESIA	315,633.00	10,670.00
GI SERVICES	95,304.00	15,045.00
EMERGENCY ROOM	2,033,893.00	13,947.00
RECOVERY ROOM	266,843.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	7,175.00	0.00
OCCUPATIONAL THERAPY	8,966.00	15,955.00
SPEECH PATHOLOGY	3,749.00	4,310.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,953.00	12,492.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	100,188.00
OTHER IMAGING SERVICE	132,338.00	5,969.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,064.00	6,153.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	267,478.00	50,894.09
AUDIOLOGY	0.00	0.00
CARDIOLOGY	360,163.00	284,703.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,663.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	150,289.57	4,967.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	53,222.00	4,278.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	5,724.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,747,164.00	779,711.00
MRI SERVICES	203,675.00	15,659.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	2,373.00	791.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	254,105.50	126,814.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,651,257.69	2,215,388.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,651,257.69	2,215,388.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,971.44	ADJUSTMENTS	0.00
COVERED CHARGES	113,957.08	CONTRACTUAL ALLOW	68,065.72
NON-COVERD CHARGES	38,014.36	TOTAL MEDICAID LIAB	45,891.36
		LESS: COB	45,870.36
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,909.94	0.00
MED/SURG SUPPLY	11,147.00	206.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,660.00	0.00
CT SCAN	3,938.00	11,814.00
PHYSICAL THERAPY	0.00	284.00
EKG/ECG	1,342.00	0.00
IV THERAPY	172.00	0.00
OPERATING ROOM	10,238.00	5,280.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,907.00	0.00
GI SERVICES	0.00	2,170.00
EMERGENCY ROOM	21,082.00	1,013.00
RECOVERY ROOM	5,166.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,197.00	734.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,466.00	7,442.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,195.00	2,118.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,031.00	5,534.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	506.14	1,419.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	113,957.08	38,014.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	113,957.08	38,014.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	903,035.75	ADJUSTMENTS	6,500.68
COVERED CHARGES	799,107.44	CONTRACTUAL ALLOW	768,284.50
NON-COVERD CHARGES	103,928.31	TOTAL MEDICAID LIAB	30,822.94
		LESS: COB	0.00
		LESS: COPAYMENT	1,335.00
		REIMBURSEMENT	29,487.94

TOTAL NUMBER OF CLAIMS 551

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,572.13	588.00	OTHER LAB	3,057.00	0.00
MED/SURG SUPPLY	17,510.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,126.00	588.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,202.00	11,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	206,358.00	88,182.00
EKG/ECG	15,023.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,865.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,343.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	378,865.00	166.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,719.31	2,548.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,275.00	368.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,192.00	0.00			

TOTAL ANCILLARY	799,107.44	103,928.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	799,107.44	103,928.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,445.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,784.00	CONTRACTUAL ALLOW	9,845.18
NON-COVERD CHARGES	1,661.00	TOTAL MEDICAID LIAB	2,938.82
		LESS: COB	2,920.82
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.27	0.00
MED/SURG SUPPLY	1,280.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	440.00	1,394.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	180.00	0.00
OPERATING ROOM	1,250.00	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	6,213.00	166.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,912.00	101.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	493.73	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,784.00	1,661.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,784.00	1,661.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,794,968.70	ADJUSTMENTS	75,914.81
COVERED CHARGES	1,695,359.23	CONTRACTUAL ALLOW	1,475,032.99
NON-COVERD CHARGES	99,609.47	TOTAL MEDICAID LIAB	220,326.24
		LESS: COB	0.00
		LESS: COPAYMENT	242.64
		REIMBURSEMENT	220,083.60

TOTAL NUMBER OF CLAIMS 41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,926.44	1,239.76
MED/SURG SUPPLY	742,079.38	58.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,418.00	5,154.00
CT SCAN	58,972.00	0.00
PHYSICAL THERAPY	0.00	284.00
EKG/ECG	14,644.00	0.00
IV THERAPY	15,118.00	0.00
OPERATING ROOM	189,878.33	3,180.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,411.00	0.00
ANESTHESIA	25,108.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,370.00	166.00
RECOVERY ROOM	27,623.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	98,119.00	0.00
OTHER IMAGING SERVICE	1,074.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	414.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,257.00	5,186.10
AUDIOLOGY	0.00	0.00
CARDIOLOGY	315,502.00	57,071.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,842.00	976.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,829.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	65,152.00	15,026.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,622.08	11,267.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,695,359.23	99,609.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,695,359.23	99,609.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,521,979.72	ADJUSTMENTS	777,383.05
COVERED CHARGES	19,307,936.28	CONTRACTUAL ALLOW	13,539,945.81
NON-COVERD CHARGES	214,043.44	TOTAL MEDICAID LIAB	5,767,990.47
		LESS: COB	152,865.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,615,124.71

TOTAL NUMBER OF ADMISSIONS 1,052

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,251	5	1,089,275.00	5,106.00
ROUTINE NURSERY	681	1	677,276.00	10,463.25
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,932	6	1,766,551.00	15,569.25
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	852	0	925,872.50	0.00
NICU	223	0	991,247.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,075	0	1,917,119.50	0.00
TOTAL ACCOMODATIONS	4,007	6	3,683,670.50	15,569.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,553,308.44	494.91
MED/SURG SUPPLY	1,268,120.22	7,443.97
LABORATORY-GENERAL	3,453,236.91	4,832.50
RADIOLOGY-DIAGNOSTIC	288,464.25	0.00
CT SCAN	850,771.80	0.00
PHYSICAL THERAPY	57,254.50	0.00
EKG/ECG	86,992.00	0.00
IV THERAPY	126,524.75	3,082.00
OPERATING ROOM	1,104,449.70	1,537.00
LABOR/DELIVERY ROOM	1,681,053.58	99,207.00
RESPIRATORY SERVICES	648,389.02	5,190.23
ANESTHESIA	156,160.00	0.00
GI SERVICES	90,389.75	0.00
EMERGENCY ROOM	730,182.85	1,250.00
RECOVERY ROOM	339,120.50	162.25
LABORATORY PATHOLOGIC	129,083.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	24,054.50	0.00
SPEECH PATHOLOGY	8,888.00	0.00
RENAL DIALYSIS	227,838.50	53,833.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	33,223.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	220,815.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	522,057.83	15,212.09
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	111,302.75	1,430.00
AUDIOLOGY	29,075.50	0.00
CARDIOLOGY	393,154.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,702.26	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	48,342.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	123,446.25	195.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	211,544.25	0.00
PROFESSIONAL FEES	0.00	444.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,095,319.42	57.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,103.00

TOTAL ANCILLARY	15,624,265.78	198,474.19
TOTAL ACCOMODATIONS	3,683,670.50	15,569.25
TOTAL CHARGES	19,307,936.28	214,043.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	9111251000061	04/12/11 - 04/13/11	09/12/11	0.00	4,103.00	0.00	2,065.94	0.00
TOTAL				0.00	4,103.00	0.00	2,065.94	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,590,435.21	ADJUSTMENTS	0.00
COVERED CHARGES	2,587,936.21	CONTRACTUAL ALLOW	1,244,754.20
NON-COVERD CHARGES	2,499.00	TOTAL MEDICAID LIAB	1,343,182.01
		LESS: COB	1,343,182.01
		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	25	0	12,275.00	0.00
ROUTINE NURSERY	22	0	61,625.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	73,900.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	8,778.00	0.00
NICU	332	0	1,491,460.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	339	0	1,500,238.00	0.00
TOTAL ACCOMODATIONS	386	0	1,574,138.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,278.43	0.00
MED/SURG SUPPLY	137,721.75	109.00
LABORATORY-GENERAL	324,269.25	0.00
RADIOLOGY-DIAGNOSTIC	13,079.25	0.00
CT SCAN	1,924.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	699.00	0.00
IV THERAPY	2,864.00	0.00
OPERATING ROOM	15,759.50	0.00
LABOR/DELIVERY ROOM	31,875.25	614.00
RESPIRATORY SERVICES	221,380.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,641.00	0.00
EMERGENCY ROOM	1,579.00	0.00
RECOVERY ROOM	2,273.00	0.00
LABORATORY PATHOLOGIC	1,470.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,570.75	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	770.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,086.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	82,581.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,803.00	0.00
AUDIOLOGY	345.00	0.00
CARDIOLOGY	4,401.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	787.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,605.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,137.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	1,776.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,898.78	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,013,798.21	2,499.00
TOTAL ACCOMODATIONS	1,574,138.00	0.00
TOTAL CHARGES	2,587,936.21	2,499.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,745,977.88	ADJUSTMENTS	449,999.68
COVERED CHARGES	9,652,645.03	CONTRACTUAL ALLOW	7,817,698.75
NON-COVERD CHARGES	1,093,332.85	TOTAL MEDICAID LIAB	1,834,946.28
		LESS: COB	23,075.86
		LESS: COPAYMENT	3,829.25
		REIMBURSEMENT	1,808,041.17
		ALL OTHER	1,655,060.22
		FEE SCHEDULE-LAB	131,514.53
		INJECTABLE DRUGS	21,466.42

TOTAL NUMBER OF CLAIMS 4,187

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	240,006.07	6,650.41	OTHER LAB	133,119.56	4,633.50
MED/SURG SUPPLY	283,494.75	151,786.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	586.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311,606.75	15,047.50	OTHER THERAPEUTIC SVC	0.00	1,568.75
CT SCAN	1,123,009.50	108,111.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,441.00	2,511.00	FEE SCHEDULE LAB	1,963,572.83	357,952.77
EKG/ECG	105,865.00	0.00	MRI SERVICES	174,909.50	16,759.50
IV THERAPY	381,552.25	42,326.00	PROFESSIONAL FEES	0.00	37.00
OPERATING ROOM	598,110.21	133,149.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,539.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,673.00	6,618.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	238,335.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	138,745.50	17,094.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,357,831.42	28,892.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236,451.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	157,185.10	138,380.29
RADIOLOGY THERAPEUTIC	29,080.75	851.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	848.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,586.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,540.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,362.00	2,663.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	13,651.00	0.00			
OTHER IMAGING SERVICE	440,130.50	30,840.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,935.54	1,770.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	93,949.25	192.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	210,104.80	9,714.70			
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/OBSERV. RM	274,987.00	5,069.00			

TOTAL ANCILLARY	9,652,645.03	1,093,332.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,652,645.03	1,093,332.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
777	5911202000098	03/17/11 - 03/17/11	07/25/11	0.00	0.00	0.00	0.00	0.00
777	5911202000098	03/17/11 - 03/17/11	07/25/11	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	169,596.40	ADJUSTMENTS	0.00
COVERED CHARGES	135,924.81	CONTRACTUAL ALLOW	92,355.12
NON-COVERD CHARGES	33,671.59	TOTAL MEDICAID LIAB	43,569.69
		LESS: COB	43,539.69
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,858.20	0.00	OTHER LAB	4,500.00	0.00
MED/SURG SUPPLY	5,446.75	4,682.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,397.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,639.00	14,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,323.50	6,010.17
EKG/ECG	2,535.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,203.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,973.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	784.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,427.00	309.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,159.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,658.50	1,842.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,608.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,047.11	2,077.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	6,441.00	4,210.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,493.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,430.25	0.00			

TOTAL ANCILLARY	135,924.81	33,671.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	135,924.81	33,671.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	946,116.79	ADJUSTMENTS	3,033.62
COVERED CHARGES	881,858.49	CONTRACTUAL ALLOW	846,841.02
NON-COVERD CHARGES	64,258.30	TOTAL MEDICAID LIAB	35,017.47
		LESS: COB	36.00
		LESS: COPAYMENT	891.07
		REIMBURSEMENT	34,090.40

TOTAL NUMBER OF CLAIMS 626

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,678.96	493.20	OTHER LAB	15,979.50	572.25
MED/SURG SUPPLY	7,750.50	384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,336.75	622.25	OTHER THERAPEUTIC SVC	0.00	210.00
CT SCAN	60,113.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	216,134.50	43,082.75
EKG/ECG	9,632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	41,203.75	3,234.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,786.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,363.00	383.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,285.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	430,528.45	3,333.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,506.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,475.58	5,277.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	41,249.75	3,806.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,660.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,781.00	0.00			

TOTAL ANCILLARY	881,858.49	64,258.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	881,858.49	64,258.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,318.93	ADJUSTMENTS	0.00
COVERED CHARGES	34,153.63	CONTRACTUAL ALLOW	27,698.03
NON-COVERD CHARGES	4,165.30	TOTAL MEDICAID LIAB	6,455.60
		LESS: COB	6,440.60
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,425.73	0.00
MED/SURG SUPPLY	273.75	49.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	158.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	4,658.50	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	13,761.50	138.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,760.25	2,093.50
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/OBSERV. RM	2,400.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,180.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,210.25	1,504.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	325.65	380.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,153.63	4,165.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,153.63	4,165.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	652,041.25	ADJUSTMENTS	63,435.31
COVERED CHARGES	568,898.07	CONTRACTUAL ALLOW	470,109.67
NON-COVERD CHARGES	83,143.18	TOTAL MEDICAID LIAB	98,788.40
		LESS: COB	1,708.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	96,912.40

TOTAL NUMBER OF CLAIMS 20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,094.99	255.02	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	87,934.14	12,852.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,736.25	4,107.50	OTHER THERAPEUTIC SVC	0.00	210.00
CT SCAN	6,492.75	1,735.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,399.50	2,332.25
EKG/ECG	466.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,714.00	6,204.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,093.37	42,851.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,860.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,632.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	853.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,431.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,753.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	68,818.82	8,301.28
RADIOLOGY THERAPEUTIC	18,540.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,271.00	1,799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,175.00	2,495.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,632.00	0.00			

TOTAL ANCILLARY	568,898.07	83,143.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	568,898.07	83,143.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE HOSPITAL, LLC
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,323,054.50	ADJUSTMENTS	551,306.60
COVERED CHARGES	23,995,536.25	CONTRACTUAL ALLOW	19,650,394.45
NON-COVERD CHARGES	327,518.25	TOTAL MEDICAID LIAB	4,345,141.80
		LESS: COB	8,797.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,336,344.39

TOTAL NUMBER OF ADMISSIONS 657

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,099	2	2,150,950.00	151,840.00
ROUTINE NURSERY	198	0	204,220.00	22,800.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,297	2	2,355,170.00	174,640.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	298	0	823,970.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	298	0	823,970.00	0.00
TOTAL ACCOMODATIONS	2,595	2	3,179,140.00	174,640.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,541,520.50	2,595.00
MED/SURG SUPPLY	1,604,631.25	6,540.25
LABORATORY-GENERAL	4,420,332.25	457.50
RADIOLOGY-DIAGNOSTIC	588,754.25	0.00
CT SCAN	1,317,231.75	35,010.50
PHYSICAL THERAPY	145,431.75	0.00
EKG/ECG	212,877.00	0.00
IV THERAPY	95,008.50	2,350.75
OPERATING ROOM	1,384,461.75	4,626.25
LABOR/DELIVERY ROOM	558,378.25	0.00
RESPIRATORY SERVICES	968,407.50	4,129.25
ANESTHESIA	764,401.00	0.00
GI SERVICES	108,813.25	0.00
EMERGENCY ROOM	683,796.25	3,317.00
RECOVERY ROOM	256,139.75	0.00
LABORATORY PATHOLOGIC	129,877.25	0.00
RADIOLOGY THERAPEUTIC	88,747.00	0.00
OCCUPATIONAL THERAPY	1,766.75	0.00
SPEECH PATHOLOGY	17,497.00	0.00
RENAL DIALYSIS	45,343.50	6,364.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	533.75	381.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	168,782.25	27,110.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	429,074.75	8,144.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	152,211.50	14,786.75
AUDIOLOGY	0.00	900.00
CARDIOLOGY	587,891.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,176.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,376.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	93,202.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	310.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	318,162.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,102,569.50	35,854.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,816,396.25	152,878.25
TOTAL ACCOMODATIONS	3,179,140.00	174,640.00
TOTAL CHARGES	23,995,536.25	327,518.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,294.50	ADJUSTMENTS	0.00
COVERED CHARGES	95,484.50	CONTRACTUAL ALLOW	63,064.79
NON-COVERD CHARGES	810.00	TOTAL MEDICAID LIAB	32,419.71
		LESS: COB	32,419.71
		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	13	0	13,690.00	810.00
ROUTINE NURSERY	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	0	13,690.00	810.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	13	0	13,690.00	810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,190.75	0.00
MED/SURG SUPPLY	6,540.25	0.00
LABORATORY-GENERAL	14,943.50	0.00
RADIOLOGY-DIAGNOSTIC	1,961.00	0.00
CT SCAN	3,293.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	490.50	0.00
IV THERAPY	745.75	0.00
OPERATING ROOM	4,986.50	0.00
LABOR/DELIVERY ROOM	19,926.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,486.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,507.75	0.00
RECOVERY ROOM	1,792.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,049.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,865.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,015.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	81,794.50	0.00
TOTAL ACCOMODATIONS	13,690.00	810.00
TOTAL CHARGES	95,484.50	810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,714,711.35	ADJUSTMENTS	119,003.82
COVERED CHARGES	16,241,214.29	CONTRACTUAL ALLOW	13,273,198.44
NON-COVERD CHARGES	1,473,497.06	TOTAL MEDICAID LIAB	2,968,015.85
		LESS: COB	7,204.75
		LESS: COPAYMENT	4,227.00
		REIMBURSEMENT	2,956,584.10
		ALL OTHER	2,768,050.68
		FEE SCHEDULE-LAB	174,548.56
		INJECTABLE DRUGS	13,984.86

TOTAL NUMBER OF CLAIMS 4,654

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	561,567.05	1,984.00	OTHER LAB	148,548.25	3,595.09
MED/SURG SUPPLY	675,202.25	2,507.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,025,809.25	42,541.25	OTHER THERAPEUTIC SVC	0.00	931.50
CT SCAN	2,531,334.75	137,061.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,251.50	2,802.25	FEE SCHEDULE LAB	3,610,823.42	559,338.62
EKG/ECG	293,010.00	981.00	MRI SERVICES	406,669.59	26,846.25
IV THERAPY	245,042.00	2,539.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	668,161.78	249,523.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,227.00	21,924.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,478.25	4,459.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	658,736.75	2,529.75	AMBULANCE	0.00	0.00
GI SERVICES	222,017.71	30,607.29	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,832,110.18	33,020.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	342,545.75	1,466.25	DRUG-SPECIFIC/HOME IV	0.00	87.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	205,385.56	138,050.50
RADIOLOGY THERAPEUTIC	166,678.25	648.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,061.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,160.75	980.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	16,092.25			
OTHER IMAGING SERVICE	705,086.50	62,631.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,730.50	2,957.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	305,259.50	90,462.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	201,729.75	25,584.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,243.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	145,405.00	10,281.75			

TOTAL ANCILLARY	16,241,214.29	1,473,497.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,241,214.29	1,473,497.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	437,175.00	ADJUSTMENTS	0.00
COVERED CHARGES	348,182.00	CONTRACTUAL ALLOW	230,757.47
NON-COVERD CHARGES	88,993.00	TOTAL MEDICAID LIAB	117,424.53
		LESS: COB	117,355.13
		LESS: COPAYMENT	69.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,177.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	51,149.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,201.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,748.75	7,238.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,973.25	21,617.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	55,619.24	12,773.25
EKG/ECG	2,943.00	0.00	MRI SERVICES	7,897.50	0.00
IV THERAPY	27,518.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,414.26	39,652.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	642.50	642.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,686.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,065.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,366.50	474.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,390.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	855.50	2,989.50
RADIOLOGY THERAPEUTIC	5,519.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	4,308.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,513.75	338.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,981.50	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/OBSERV. RM	1,410.00	0.00			

TOTAL ANCILLARY	348,182.00	88,993.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	348,182.00	88,993.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,290,239.11	ADJUSTMENTS	700.21
COVERED CHARGES	1,221,473.98	CONTRACTUAL ALLOW	1,184,435.52
NON-COVERD CHARGES	68,765.13	TOTAL MEDICAID LIAB	37,038.46
		LESS: COB	0.00
		LESS: COPAYMENT	1,323.05
		REIMBURSEMENT	35,715.41

TOTAL NUMBER OF CLAIMS 667

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,994.35	0.00
MED/SURG SUPPLY	18,542.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,578.50	0.00
CT SCAN	81,661.00	9,879.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	19,129.50	0.00
IV THERAPY	11,907.75	0.00
OPERATING ROOM	4,797.88	4,797.88
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,037.75	412.00
ANESTHESIA	5,665.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	537,609.50	2,176.50
RECOVERY ROOM	2,941.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	18,461.75	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	53,101.75	4,852.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	776.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,090.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,751.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	336,907.00	32,256.75
MRI SERVICES	8,039.75	3,655.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,257.00	9,958.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,221,473.98	68,765.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,221,473.98	68,765.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,156.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,155.00	CONTRACTUAL ALLOW	20,812.37
NON-COVERD CHARGES	7,001.50	TOTAL MEDICAID LIAB	8,342.63
		LESS: COB	8,324.63
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	638.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	186.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,438.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,907.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,363.50	1,005.25
EKG/ECG	0.00	0.00	MRI SERVICES	3,655.75	3,655.75
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,864.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,075.75	2,340.50			
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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,155.00	7,001.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,155.00	7,001.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,709,451.96	ADJUSTMENTS	0.00
COVERED CHARGES	3,245,201.13	CONTRACTUAL ALLOW	2,729,372.48
NON-COVERD CHARGES	464,250.83	TOTAL MEDICAID LIAB	515,828.65
		LESS: COB	0.00
		LESS: COPAYMENT	1,073.29
		REIMBURSEMENT	514,755.36

TOTAL NUMBER OF CLAIMS 104

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,332.00	0.00
MED/SURG SUPPLY	519,187.75	72,760.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,098.75	35,780.50
CT SCAN	130,285.00	17,723.75
PHYSICAL THERAPY	0.00	2,792.00
EKG/ECG	17,658.00	490.50
IV THERAPY	69,723.25	0.00
OPERATING ROOM	558,178.89	233,839.58
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,890.75	574.50
ANESTHESIA	428,910.25	0.00
GI SERVICES	2,667.75	889.25
EMERGENCY ROOM	56,023.75	954.00
RECOVERY ROOM	128,424.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	741,452.25	5,513.75
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	346.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	529.25	27.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	29,945.25	1,170.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,742.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	63,220.00	15,514.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	57,462.25	15,302.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	42,983.25	6,173.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	699.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	51.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	148,958.75	25,393.00
MRI SERVICES	21,746.50	7,551.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,081.24	21,403.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,245,201.13	464,250.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,245,201.13	464,250.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA CARTERSVILLE, LLC
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	104,546,330.53	ADJUSTMENTS	16,585,785.00
COVERED CHARGES	100,187,731.43	CONTRACTUAL ALLOW	60,190,951.45
NON-COVERD CHARGES	4,358,599.10	TOTAL MEDICAID LIAB	39,996,779.98
		LESS: COB	276,618.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,720,161.64

TOTAL NUMBER OF ADMISSIONS 2,484

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,077	18	9,662,727.00	3,826,647.00
ROUTINE NURSERY	914	0	1,675,882.00	11,606.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	11,991	22	11,338,609.00	3,838,253.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	11,772.00	0.00
NICU	899	0	3,824,724.50	0.00
PED ICU	3,116	0	9,916,281.00	0.00
NEURO ICU	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	12	0.00	28,392.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,024	12	13,752,777.50	28,392.00
TOTAL ACCOMODATIONS	16,015	34	25,091,386.50	3,866,645.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,252,688.65	81,897.10
MED/SURG SUPPLY	11,909,454.21	40,694.00
LABORATORY-GENERAL	8,604,916.32	11,259.00
RADIOLOGY-DIAGNOSTIC	1,411,484.50	2,421.50
CT SCAN	1,303,218.00	77,502.00
PHYSICAL THERAPY	447,624.50	0.00
EKG/ECG	32,735.50	0.00
IV THERAPY	25,391.00	1,246.00
OPERATING ROOM	7,026,389.00	34,989.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,764,800.00	26,683.00
ANESTHESIA	2,814,597.00	1,726.00
GI SERVICES	194,581.00	2,553.00
EMERGENCY ROOM	2,925,081.00	47,878.50
RECOVERY ROOM	776,482.00	0.00
LABORATORY PATHOLOGIC	601,191.00	294.00
RADIOLOGY THERAPEUTIC	123,767.50	1,900.00
OCCUPATIONAL THERAPY	219,937.00	655.00
SPEECH PATHOLOGY	296,754.00	0.00
RENAL DIALYSIS	0.00	17,766.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	357.50	21,419.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	237,929.50	10,689.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	688,225.50	2,233.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	97,032.50	1,385.50
AUDIOLOGY	30,826.00	577.50
CARDIOLOGY	501,333.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,247,638.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	109,614.50	465.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	156,149.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	15,249.00	54,898.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,279,781.50	0.00
PROFESSIONAL FEES	0.00	25,699.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,116.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	25,123.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	75,096,344.93	491,953.60
TOTAL ACCOMODATIONS	25,091,386.50	3,866,645.50
TOTAL CHARGES	100,187,731.43	4,358,599.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,697,885.80	ADJUSTMENTS	0.00
COVERED CHARGES	3,528,665.30	CONTRACTUAL ALLOW	1,274,918.40
NON-COVERD CHARGES	169,220.50	TOTAL MEDICAID LIAB	2,253,746.90
		LESS: COB	2,253,746.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 85

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	352	0	303,231.00	129,110.00
ROUTINE NURSERY	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	352	0	303,231.00	129,110.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	9	0	38,160.00	0.00
PED ICU	87	0	276,312.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	96	0	314,472.00	0.00
TOTAL ACCOMODATIONS	448	0	617,703.00	129,110.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	625,709.25	0.00
MED/SURG SUPPLY	671,115.05	0.00
LABORATORY-GENERAL	272,418.00	0.00
RADIOLOGY-DIAGNOSTIC	52,139.50	0.00
CT SCAN	42,803.50	2,640.50
PHYSICAL THERAPY	12,155.00	0.00
EKG/ECG	633.00	0.00
IV THERAPY	744.00	0.00
OPERATING ROOM	274,410.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	415,397.50	0.00
ANESTHESIA	110,737.00	0.00
GI SERVICES	6,347.00	0.00
EMERGENCY ROOM	88,909.00	0.00
RECOVERY ROOM	29,924.00	0.00
LABORATORY PATHOLOGIC	9,618.50	0.00
RADIOLOGY THERAPEUTIC	178.00	0.00
OCCUPATIONAL THERAPY	4,946.00	0.00
SPEECH PATHOLOGY	389.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	345.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,903.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,539.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,480.00	0.00
AUDIOLOGY	234.00	0.00
CARDIOLOGY	13,381.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	217,508.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,308.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,820.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,706.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	30,215.00	0.00
PROFESSIONAL FEES	0.00	34,419.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,910,962.30	40,110.50
TOTAL ACCOMODATIONS	617,703.00	129,110.00
TOTAL CHARGES	3,528,665.30	169,220.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,424,278.16	ADJUSTMENTS	1,852,132.83
COVERED CHARGES	33,742,392.97	CONTRACTUAL ALLOW	21,906,972.11
NON-COVERD CHARGES	1,681,885.19	TOTAL MEDICAID LIAB	11,835,420.86
		LESS: COB	166,170.48
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	11,669,085.38
		ALL OTHER	10,752,665.74
		FEE SCHEDULE-LAB	358,118.34
		INJECTABLE DRUGS	558,301.30
		TOTAL NUMBER OF CLAIMS	19,300

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,719,603.75	13,263.00
MED/SURG SUPPLY	2,218,534.83	18,038.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,422,910.00	7,760.50
CT SCAN	1,980,730.00	133,617.50
PHYSICAL THERAPY	701,992.50	20,612.50
EKG/ECG	18,779.00	0.00
IV THERAPY	412,613.00	2,167.50
OPERATING ROOM	3,195,573.01	241,333.41
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	199,930.00	7,752.00
ANESTHESIA	1,402,049.00	675.00
GI SERVICES	464,250.00	14,402.00
EMERGENCY ROOM	4,319,815.50	10,031.00
RECOVERY ROOM	614,795.00	861.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	631,946.50	3,133.50
OCCUPATIONAL THERAPY	320,650.00	16,600.00
SPEECH PATHOLOGY	358,118.00	17,092.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,144,053.50	31,333.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	520,627.50	3,971.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	522,094.00	6,676.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	262,966.00	54,327.00
AUDIOLOGY	275,676.50	78.00
CARDIOLOGY	69,616.00	396.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,382,135.00	2,352.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	423,306.50	14,824.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	159,610.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,066.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,906.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,366,881.38	646,722.28
MRI SERVICES	2,919,184.50	240,184.50
PROFESSIONAL FEES	0.00	29,242.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,710,886.00	124,772.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	17,761.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,742,392.97	1,681,885.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,742,392.97	1,681,885.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,221,908.35	ADJUSTMENTS	0.00
COVERED CHARGES	2,634,195.10	CONTRACTUAL ALLOW	780,017.82
NON-COVERD CHARGES	587,713.25	TOTAL MEDICAID LIAB	1,854,177.28
		LESS: COB	1,854,150.28
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,303

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,954.25	2,851.00
MED/SURG SUPPLY	275,897.75	5,050.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,438.00	458.00
CT SCAN	93,091.00	67,919.50
PHYSICAL THERAPY	17,321.50	7,813.00
EKG/ECG	422.00	0.00
IV THERAPY	17,783.00	0.00
OPERATING ROOM	222,792.00	121,888.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,498.50	3,652.50
ANESTHESIA	166,984.00	0.00
GI SERVICES	36,348.50	1,712.50
EMERGENCY ROOM	311,885.00	5,083.50
RECOVERY ROOM	72,493.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	82,203.50	11,846.00
OCCUPATIONAL THERAPY	8,763.50	5,190.50
SPEECH PATHOLOGY	2,723.50	16,355.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	51,754.50	665.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	31,365.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,466.50	20,292.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,227.00	2,955.50
AUDIOLOGY	6,811.50	1,393.50
CARDIOLOGY	1,805.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	147,625.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	26,987.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,902.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	438.00	0.00
OTHER THERAPEUTIC SVC	0.00	612.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	344,316.60	31,795.50
MRI SERVICES	307,914.50	140,572.50
PROFESSIONAL FEES	0.00	133,198.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80,981.50	6,409.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,634,195.10	587,713.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,634,195.10	587,713.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	851,637.50	ADJUSTMENTS	2,069.78
COVERED CHARGES	815,571.00	CONTRACTUAL ALLOW	764,652.30
NON-COVERD CHARGES	36,066.50	TOTAL MEDICAID LIAB	50,918.70
		LESS: COB	1,334.04
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	49,578.66

TOTAL NUMBER OF CLAIMS 888

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,104.25	1,492.50
MED/SURG SUPPLY	23,919.75	1,873.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,622.50	465.50
CT SCAN	31,904.50	3,082.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,688.00	0.00
IV THERAPY	70.00	289.00
OPERATING ROOM	22,152.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,269.50	189.00
ANESTHESIA	6,978.00	0.00
GI SERVICES	2,553.00	0.00
EMERGENCY ROOM	489,922.50	836.00
RECOVERY ROOM	2,429.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	185.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,715.00	516.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,834.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,610.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,628.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,566.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	762.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	114,102.00	21,427.00
MRI SERVICES	11,590.00	2,242.50
PROFESSIONAL FEES	0.00	3,231.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,964.50	420.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	815,571.00	36,066.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	815,571.00	36,066.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,103.25	ADJUSTMENTS	0.00
COVERED CHARGES	29,581.50	CONTRACTUAL ALLOW	7,039.49
NON-COVERD CHARGES	11,521.75	TOTAL MEDICAID LIAB	22,542.01
		LESS: COB	22,536.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71.50	59.25
MED/SURG SUPPLY	78.00	351.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,849.00	237.00
CT SCAN	0.00	1,624.50
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	19,011.00	466.50
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 SERVICE	557.50	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,745.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,219.50	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	8,726.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	57.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	29,581.50	11,521.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,581.50	11,521.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,048,024.21	ADJUSTMENTS	436,150.88
COVERED CHARGES	7,801,142.08	CONTRACTUAL ALLOW	6,086,185.49
NON-COVERD CHARGES	246,882.13	TOTAL MEDICAID LIAB	1,714,956.59
		LESS: COB	224,416.89
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	1,490,530.70

TOTAL NUMBER OF CLAIMS 223

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,375.75	643.00
MED/SURG SUPPLY	4,218,793.21	10,210.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,167.00	1,584.00
CT SCAN	56,989.00	17,679.00
PHYSICAL THERAPY	163,060.00	7,039.50
EKG/ECG	211.00	0.00
IV THERAPY	248.00	0.00
OPERATING ROOM	1,320,069.37	178,331.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,593.50	0.00
ANESTHESIA	674,012.00	0.00
GI SERVICES	5,137.50	0.00
EMERGENCY ROOM	64,748.50	289.00
RECOVERY ROOM	144,747.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,753.50	0.00
OCCUPATIONAL THERAPY	167,059.00	1,817.00
SPEECH PATHOLOGY	171,146.00	2,477.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,046.00	450.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,402.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,997.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,827.50	837.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,244.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	79,135.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,933.00	1,015.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	451.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	88,832.00	13,884.50
MRI SERVICES	179,283.50	3,993.00
PROFESSIONAL FEES	0.00	661.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	109,330.25	3,291.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	2,227.50
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,801,142.08	246,882.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,801,142.08	246,882.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/11	THROUGH	12/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	279,616.36	ADJUSTMENTS	0.00
COVERED CHARGES	233,459.11	CONTRACTUAL ALLOW	45,041.70
NON-COVERD CHARGES	46,157.25	TOTAL MEDICAID LIAB	188,417.41
		LESS: COB	188,417.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCOTTISH RITE
1584 TULLIE CIR NE
ATLANTA,GA 30329-2311

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,755.00	321.50
MED/SURG SUPPLY	114,382.86	3,110.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,046.00	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	19,476.00	42,197.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	69.00	0.00
ANESTHESIA	25,536.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	4,324.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	785.50	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	120.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	477.50	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	1,805.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,145.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,406.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,450.50	364.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,398.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,282.25	163.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	233,459.11	46,157.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	233,459.11	46,157.25

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,834.65	ADJUSTMENTS	7,924.86
COVERED CHARGES	183,834.65	CONTRACTUAL ALLOW	52,006.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	131,828.18
		LESS: COB	2,128.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	129,699.49

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	75	0	56,175.00	0.00
ROUTINE NURSERY	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	56,175.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	75	0	56,175.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,925.40	0.00
MED/SURG SUPPLY	22,567.30	0.00
LABORATORY-GENERAL	23,342.95	0.00
RADIOLOGY-DIAGNOSTIC	3,201.00	0.00
CT SCAN	5,486.00	0.00
PHYSICAL THERAPY	861.00	0.00
EKG/ECG	2,760.00	0.00
IV THERAPY	1,372.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,153.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,090.00	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	51.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,934.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	475.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	440.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	127,659.65	0.00
TOTAL ACCOMODATIONS	56,175.00	0.00
TOTAL CHARGES	183,834.65	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	341,360.56	ADJUSTMENTS	102.87
COVERED CHARGES	315,274.51	CONTRACTUAL ALLOW	205,006.30
NON-COVERD CHARGES	26,086.05	TOTAL MEDICAID LIAB	110,268.21
		LESS: COB	0.00
		LESS: COPAYMENT	834.00
		REIMBURSEMENT	109,434.21
		ALL OTHER	99,145.01
		FEE SCHEDULE-LAB	10,213.98
		INJECTABLE DRUGS	75.22

TOTAL NUMBER OF CLAIMS 546

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,870.25	967.00
MED/SURG SUPPLY	11,078.76	569.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,474.50	276.00
CT SCAN	26,065.60	0.00
PHYSICAL THERAPY	176.50	0.00
EKG/ECG	6,840.00	0.00
IV THERAPY	1,982.50	0.00
OPERATING ROOM	19,806.00	1,757.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,933.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	114,986.00	889.00
RECOVERY ROOM	4,790.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	51.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,120.55	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,660.65	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,008.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,303.70	21,520.55
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	178.00	56.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	315,274.51	26,086.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	315,274.51	26,086.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,504.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,030.50	CONTRACTUAL ALLOW	2,456.51
NON-COVERD CHARGES	474.00	TOTAL MEDICAID LIAB	1,573.99
		LESS: COB	1,570.99
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	159.00	54.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	224.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	402.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	814.00	420.00
EKG/ECG	240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	152.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,985.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,030.50	474.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,030.50	474.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,057.45	ADJUSTMENTS	0.00
COVERED CHARGES	38,547.50	CONTRACTUAL ALLOW	35,156.50
NON-COVERD CHARGES	509.95	TOTAL MEDICAID LIAB	3,391.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	3,289.00

TOTAL NUMBER OF CLAIMS 68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,535.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	685.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,161.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,695.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,659.65	473.95
EKG/ECG	360.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	457.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,878.00	36.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61.00	0.00			

TOTAL ANCILLARY	38,547.50	509.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,547.50	509.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 12/05/10
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	223,965.75	ADJUSTMENTS	0.00
COVERED CHARGES	223,180.35	CONTRACTUAL ALLOW	113,518.60
NON-COVERD CHARGES	785.40	TOTAL MEDICAID LIAB	109,661.75
		LESS: COB	527.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	109,133.77

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	64	0	47,936.00	0.00
ROUTINE NURSERY	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	64	0	47,936.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	64	0	47,936.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,297.71	0.00	OTHER LAB	634.20	0.00
MED/SURG SUPPLY	20,693.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,452.85	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,952.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,402.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	832.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,654.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	951.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,628.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,762.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,613.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,393.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	474.00	0.00			
BLOOD	915.20	0.00			
BLOOD STORAGE & PRO.	0.00	785.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	550.75	0.00			

TOTAL ANCILLARY	175,244.35	785.40
TOTAL ACCOMODATIONS	47,936.00	0.00
TOTAL CHARGES	223,180.35	785.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	630,225.57	ADJUSTMENTS	12,545.06
COVERED CHARGES	474,557.82	CONTRACTUAL ALLOW	335,262.83
NON-COVERD CHARGES	155,667.75	TOTAL MEDICAID LIAB	139,294.99
		LESS: COB	640.60
		LESS: COPAYMENT	912.00
		REIMBURSEMENT	137,742.39
		ALL OTHER	123,105.60
		FEE SCHEDULE-LAB	14,586.74
		INJECTABLE DRUGS	50.05

TOTAL NUMBER OF CLAIMS 645

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,785.65	36,399.25
MED/SURG SUPPLY	7,392.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,059.08	149.00
CT SCAN	32,762.60	13,089.40
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,496.75	0.00
IV THERAPY	6,738.70	0.00
OPERATING ROOM	26,865.65	52,329.60
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,077.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	136,809.65	278.00
RECOVERY ROOM	479.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
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	0.00	0.00
OTHER IMAGING SERVICE	27,944.20	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/OBSERV. RM	8,849.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	787.38	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	159,968.77	47,028.35
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	540.65	6,377.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	474,557.82	155,667.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	474,557.82	155,667.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,690.45	ADJUSTMENTS	0.00
COVERED CHARGES	1,346.65	CONTRACTUAL ALLOW	794.82
NON-COVERD CHARGES	343.80	TOTAL MEDICAID LIAB	551.83
		LESS: COB	551.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.00	327.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	264.85	15.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	190.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	812.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,346.65	343.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,346.65	343.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,426.46	ADJUSTMENTS	47.00
COVERED CHARGES	49,093.31	CONTRACTUAL ALLOW	44,893.31
NON-COVERD CHARGES	1,333.15	TOTAL MEDICAID LIAB	4,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	4,035.00

TOTAL NUMBER OF CLAIMS 84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,053.80	533.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	96.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,039.27	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,334.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,745.05	769.50
EKG/ECG	464.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	555.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	106.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,131.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	260.70	30.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	305.24	0.00			

TOTAL ANCILLARY	49,093.31	1,333.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,093.31	1,333.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/06/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107,514.97	ADJUSTMENTS	0.00
COVERED CHARGES	106,933.07	CONTRACTUAL ALLOW	80,344.07
NON-COVERD CHARGES	581.90	TOTAL MEDICAID LIAB	26,589.00
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	26,577.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	506.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,066.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	550.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	196.35	31.90
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,164.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	106,933.07	581.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	106,933.07	581.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
210 E. DERENNE AVE.
SAVANNAH,GA 31405-6736

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/06/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,834,774.21	ADJUSTMENTS	32,919.59
COVERED CHARGES	1,765,201.21	CONTRACTUAL ALLOW	1,094,844.60
NON-COVERD CHARGES	69,573.00	TOTAL MEDICAID LIAB	670,356.61
		LESS: COB	13,052.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	657,303.96

TOTAL NUMBER OF ADMISSIONS 138

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	259	0	128,697.00	61,905.00
ROUTINE NURSERY	44	0	17,253.00	37.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	303	0	145,950.00	61,942.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	63	0	143,437.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	63	0	143,437.00	0.00
TOTAL ACCOMODATIONS	366	0	289,387.00	61,942.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	149,043.02	0.00
MED/SURG SUPPLY	276,834.00	0.00
LABORATORY-GENERAL	181,514.00	0.00
RADIOLOGY-DIAGNOSTIC	23,366.00	0.00
CT SCAN	51,686.00	0.00
PHYSICAL THERAPY	4,897.00	0.00
EKG/ECG	29,771.00	0.00
IV THERAPY	12,203.00	0.00
OPERATING ROOM	106,935.00	0.00
LABOR/DELIVERY ROOM	106,072.00	0.00
RESPIRATORY SERVICES	53,005.00	0.00
ANESTHESIA	22,864.00	0.00
GI SERVICES	9,558.00	0.00
EMERGENCY ROOM	17,904.00	0.00
RECOVERY ROOM	14,346.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	308.00	0.00
RENAL DIALYSIS	15,822.00	7,396.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	125.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,679.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	40,361.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,769.00	110.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	46,407.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	569.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,505.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,846.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,339.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,122.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	269,089.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,475,814.21	7,631.00
TOTAL ACCOMODATIONS	289,387.00	61,942.00
TOTAL CHARGES	1,765,201.21	69,573.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,647,946.35	ADJUSTMENTS	33,990.18
COVERED CHARGES	2,312,879.90	CONTRACTUAL ALLOW	1,719,970.80
NON-COVERD CHARGES	335,066.45	TOTAL MEDICAID LIAB	592,909.10
		LESS: COB	540.55
		LESS: COPAYMENT	1,650.00
		REIMBURSEMENT	590,718.55
		ALL OTHER	529,172.71
		FEE SCHEDULE-LAB	49,558.35
		INJECTABLE DRUGS	11,987.49

TOTAL NUMBER OF CLAIMS 1,700

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,912.04	1,683.00
MED/SURG SUPPLY	400,122.00	18,412.00
LABORATORY-GENERAL	0.00	647.00
RADIOLOGY-DIAGNOSTIC	100,401.00	3,912.00
CT SCAN	123,192.00	13,006.00
PHYSICAL THERAPY	0.00	2,782.00
EKG/ECG	42,410.00	3,192.00
IV THERAPY	74,635.00	4,580.00
OPERATING ROOM	320,316.00	120,319.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,701.00	1,626.00
ANESTHESIA	142,935.00	0.00
GI SERVICES	34,174.00	19,110.00
EMERGENCY ROOM	111,660.00	0.00
RECOVERY ROOM	106,585.00	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	1,030.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	51,501.00	7,650.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,012.00	0.00
OTHER IMAGING SERVICE	53,746.00	3,838.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,014.00	549.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,542.00	206.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,984.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,690.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	88,917.00	1,740.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	41,913.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	259,876.74	75,109.45
MRI SERVICES	38,604.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	82,037.12	55,675.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,312,879.90	335,066.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,312,879.90	335,066.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,470.00	ADJUSTMENTS	0.00
COVERED CHARGES	59,495.00	CONTRACTUAL ALLOW	32,486.87
NON-COVERD CHARGES	28,975.00	TOTAL MEDICAID LIAB	27,008.13
		LESS: COB	26,984.13
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,070.00	1,097.00
MED/SURG SUPPLY	5,715.00	525.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,550.00	0.00
CT SCAN	1,983.00	6,684.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	350.00	0.00
IV THERAPY	980.00	198.00
OPERATING ROOM	10,647.00	6,226.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	456.00	938.00
ANESTHESIA	5,581.00	1,260.00
GI SERVICES	0.00	5,430.00
EMERGENCY ROOM	2,454.00	0.00
RECOVERY ROOM	5,449.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	590.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,321.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,261.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,499.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,942.00	670.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,647.00	5,947.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	59,495.00	28,975.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,495.00	28,975.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	92,484.00	ADJUSTMENTS	217.76
COVERED CHARGES	84,284.00	CONTRACTUAL ALLOW	76,060.82
NON-COVERD CHARGES	8,200.00	TOTAL MEDICAID LIAB	8,223.18
		LESS: COB	62.73
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	7,875.45

TOTAL NUMBER OF CLAIMS 147

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	912.00	0.00
MED/SURG SUPPLY	564.00	11.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,892.00	194.00
CT SCAN	1,488.00	1,488.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	700.00	0.00
IV THERAPY	5,657.00	132.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	743.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,348.00	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 SERVICE	5,486.00	1,338.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,392.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,970.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,394.00	1,549.00
MRI SERVICES	2,228.00	2,228.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,510.00	1,260.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	84,284.00	8,200.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	84,284.00	8,200.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,396.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,287.00	CONTRACTUAL ALLOW	802.07
NON-COVERD CHARGES	109.00	TOTAL MEDICAID LIAB	484.93
		LESS: COB	484.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	142.00	109.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	570.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	566.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,287.00	109.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,287.00	109.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	763,098.00	ADJUSTMENTS	5,208.10
COVERED CHARGES	705,219.00	CONTRACTUAL ALLOW	531,653.71
NON-COVERD CHARGES	57,879.00	TOTAL MEDICAID LIAB	173,565.29
		LESS: COB	104.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	173,437.29

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,976.00	523.00
MED/SURG SUPPLY	320,101.00	6,344.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,465.00	432.00
CT SCAN	0.00	1,488.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,400.00	0.00
IV THERAPY	58.00	0.00
OPERATING ROOM	230,406.00	41,986.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,389.00	0.00
ANESTHESIA	39,781.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	566.00	0.00
RECOVERY ROOM	32,046.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,115.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	566.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,720.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,776.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,424.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,216.00	980.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,329.00	5,011.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	705,219.00	57,879.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	705,219.00	57,879.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SMITH OF GEORGIA, LLC
PO BOX 10010
VALDOSTA,GA 31604-0010

PROVIDER NUMBER
000001691A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,789,595.09	ADJUSTMENTS	46,389.08
COVERED CHARGES	2,614,279.99	CONTRACTUAL ALLOW	1,749,171.07
NON-COVERD CHARGES	175,315.10	TOTAL MEDICAID LIAB	865,108.92
		LESS: COB	971.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	864,137.20

TOTAL NUMBER OF ADMISSIONS 121

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	614	0	444,843.00	36,447.00
ROUTINE NURSERY	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	614	0	444,843.00	36,447.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	46	0	89,038.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	46	0	89,038.00	0.00
TOTAL ACCOMODATIONS	660	0	533,881.00	36,447.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,025.54	75.00
MED/SURG SUPPLY	53,105.66	0.00
LABORATORY-GENERAL	441,690.49	2,313.19
RADIOLOGY-DIAGNOSTIC	62,326.93	589.61
CT SCAN	115,744.75	82,952.00
PHYSICAL THERAPY	16,630.55	0.00
EKG/ECG	80,863.48	202.00
IV THERAPY	25,073.34	0.00
OPERATING ROOM	71,854.09	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	156,649.69	14,816.48
ANESTHESIA	37,461.87	0.00
GI SERVICES	36,845.05	0.00
EMERGENCY ROOM	164,050.43	0.00
RECOVERY ROOM	20,732.84	0.00
LABORATORY PATHOLOGIC	10,979.53	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,824.82	0.00
SPEECH PATHOLOGY	170.94	0.00
RENAL DIALYSIS	65,391.00	10,131.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	132.68	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,232.06	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	34,425.47	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,369.49	3,622.67
AUDIOLOGY	0.00	0.00
CARDIOLOGY	65,415.28	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,752.73	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,270.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	19,280.09	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,821.26
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	79,960.55	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	353,139.64	16,049.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	5,295.71

TOTAL ANCILLARY	2,080,398.99	138,868.10
TOTAL ACCOMODATIONS	533,881.00	36,447.00
TOTAL CHARGES	2,614,279.99	175,315.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2211165010441	06/01/11 - 06/03/11	06/20/11	0.00	2,731.71	0.00	0.00	0.00
618	2212025008923	01/14/11 - 01/16/11	01/30/12	0.00	2,564.00	0.00	0.00	0.00
TOTAL				0.00	5,295.71	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,434,776.45	ADJUSTMENTS	1,478.30
COVERED CHARGES	2,931,893.20	CONTRACTUAL ALLOW	2,252,270.98
NON-COVERD CHARGES	502,883.25	TOTAL MEDICAID LIAB	679,622.22
		LESS: COB	6,309.89
		LESS: COPAYMENT	912.00
		REIMBURSEMENT	672,400.33
		ALL OTHER	618,441.93
		FEE SCHEDULE-LAB	51,959.84
		INJECTABLE DRUGS	1,998.56

TOTAL NUMBER OF CLAIMS 1,546

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,479.30	19,782.36
MED/SURG SUPPLY	84,397.24	505.16
LABORATORY-GENERAL	0.00	17,308.97
RADIOLOGY-DIAGNOSTIC	185,005.03	6,657.11
CT SCAN	351,166.31	184,998.18
PHYSICAL THERAPY	0.00	2,064.70
EKG/ECG	35,528.91	1,295.15
IV THERAPY	106,983.36	2,994.55
OPERATING ROOM	65,723.26	46,110.68
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	22,768.74	3,626.28
ANESTHESIA	61,895.23	607.62
GI SERVICES	53,591.65	14,671.25
EMERGENCY ROOM	901,553.30	3,824.41
RECOVERY ROOM	55,450.39	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	865.09
SPEECH PATHOLOGY	0.00	170.94
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,149.48
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	77,024.52	74,208.04
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,478.79	1,061.99
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	66,535.83	9,349.78
AUDIOLOGY	0.00	0.00
CARDIOLOGY	44,263.02	969.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	178,443.11	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,342.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	26,217.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	16,652.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	475,171.47	60,689.20
MRI SERVICES	60,046.48	16,449.91
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,827.38	13,596.64
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	678.76
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,596.00

TOTAL ANCILLARY	2,931,893.20	502,883.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,931,893.20	502,883.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011091008099	02/28/11 - 02/28/11	04/04/11	0.00	2,461.00	0.00	0.00	0.00
3001	2211202014613	07/11/11 - 07/11/11	07/25/11	0.00	135.00	0.00	0.00	0.00
TOTAL				0.00	2,596.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,652.70	ADJUSTMENTS	0.00
COVERED CHARGES	25,227.25	CONTRACTUAL ALLOW	14,881.19
NON-COVERD CHARGES	1,425.45	TOTAL MEDICAID LIAB	10,346.06
		LESS: COB	10,337.06
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318.81	147.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	758.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,501.83	0.00	OTHER THERAPEUTIC SVC	0.00	441.31
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,064.06	713.74
EKG/ECG	436.46	0.00	MRI SERVICES	2,506.00	0.00
IV THERAPY	169.95	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,746.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,880.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,818.73	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,590.63	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	88.46	123.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,031.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,524.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	792.00	0.00			

TOTAL ANCILLARY	25,227.25	1,425.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,227.25	1,425.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	430,374.52	ADJUSTMENTS	323.64
COVERED CHARGES	388,285.99	CONTRACTUAL ALLOW	366,525.33
NON-COVERD CHARGES	42,088.53	TOTAL MEDICAID LIAB	21,760.66
		LESS: COB	0.00
		LESS: COPAYMENT	690.00
		REIMBURSEMENT	21,070.66

TOTAL NUMBER OF CLAIMS 389

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.21	895.00
MED/SURG SUPPLY	1,382.47	98.50
LABORATORY-GENERAL	0.00	2,260.21
RADIOLOGY-DIAGNOSTIC	17,233.18	0.00
CT SCAN	31,197.24	22,791.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,921.38	0.00
IV THERAPY	11,963.60	785.99
OPERATING ROOM	401.10	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,084.70	83.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	238,477.27	841.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,709.10	7,380.85
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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,872.06	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,638.54	6,383.22
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	226.14	569.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	388,285.99	42,088.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	388,285.99	42,088.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,332.62	ADJUSTMENTS	0.00
COVERED CHARGES	4,284.93	CONTRACTUAL ALLOW	2,737.90
NON-COVERD CHARGES	47.69	TOTAL MEDICAID LIAB	1,547.03
		LESS: COB	1,541.03
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	546.66	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,729.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	47.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,284.93	47.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,284.93	47.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	174,050.70	ADJUSTMENTS	0.00
COVERED CHARGES	160,601.26	CONTRACTUAL ALLOW	124,460.05
NON-COVERD CHARGES	13,449.44	TOTAL MEDICAID LIAB	36,141.21
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	36,120.21

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	560.25	5,395.00
MED/SURG SUPPLY	40,100.90	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	289.71	289.71
CT SCAN	3,397.71	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	218.23	0.00
IV THERAPY	2,046.32	0.00
OPERATING ROOM	99,132.12	5,290.12
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	783.52	342.39
ANESTHESIA	859.14	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,100.04	0.00
RECOVERY ROOM	1,193.25	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 SERVICE	585.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,195.58	92.13
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,448.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	792.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,558.74
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,898.79	409.35
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	72.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	160,601.26	13,449.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	160,601.26	13,449.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,840,794.45	ADJUSTMENTS	4,006,022.45
COVERED CHARGES	66,753,716.99	CONTRACTUAL ALLOW	54,262,888.03
NON-COVERD CHARGES	3,087,077.46	TOTAL MEDICAID LIAB	12,490,828.96
		LESS: COB	131,148.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,359,680.59

TOTAL NUMBER OF ADMISSIONS 2,224

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,448	148	5,052,038.49	1,620,233.68
ROUTINE NURSERY	1,636	0	1,623,232.38	669,669.29
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	20	0.00	0.00
TOTAL ROUTINE	7,084	168	6,675,270.87	2,289,902.97
SPECIAL CARE SERVICES				
CCU	2,161	0	4,577,686.60	0.00
ICU	509	2	1,739,220.83	6,374.28
NICU	77	0	238,104.89	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,747	2	6,555,012.32	6,374.28
TOTAL ACCOMODATIONS	9,831	170	13,230,283.19	2,296,277.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,462,761.66	10,636.58
MED/SURG SUPPLY	5,339,767.72	80,817.02
LABORATORY-GENERAL	10,379,757.66	8,815.33
RADIOLOGY-DIAGNOSTIC	1,080,086.18	565.67
CT SCAN	1,610,529.44	435,759.90
PHYSICAL THERAPY	100,546.25	602.94
EKG/ECG	365,554.98	0.00
IV THERAPY	53,997.47	0.00
OPERATING ROOM	3,391,836.07	10,262.64
LABOR/DELIVERY ROOM	2,129,677.63	0.00
RESPIRATORY SERVICES	3,938,067.24	4,487.53
ANESTHESIA	1,632,510.00	0.00
GI SERVICES	149,922.92	0.00
EMERGENCY ROOM	1,744,961.90	27,201.32
RECOVERY ROOM	1,230,889.90	0.00
LABORATORY PATHOLOGIC	383,869.70	1,458.77
RADIOLOGY THERAPEUTIC	7,956.96	0.00
OCCUPATIONAL THERAPY	54,693.53	0.00
SPEECH PATHOLOGY	54,205.39	141.57
RENAL DIALYSIS	451,995.05	83,760.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	19,352.88	2,095.26
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	708,997.43	1,674.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	986,019.41	120,306.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	442,041.24	0.00
AUDIOLOGY	160,567.95	0.00
CARDIOLOGY	707,720.78	2,214.78
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	53,228.39	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	71,439.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	320,001.88	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,854.11	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	488,327.54	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	295.48	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	53,523,433.80	790,800.21
TOTAL ACCOMODATIONS	13,230,283.19	2,296,277.25
TOTAL CHARGES	66,753,716.99	3,087,077.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,503.85	ADJUSTMENTS	0.00
COVERED CHARGES	184,098.65	CONTRACTUAL ALLOW	118,358.92
NON-COVERD CHARGES	25,405.20	TOTAL MEDICAID LIAB	65,739.73
		LESS: COB	65,739.73
		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	12	0	11,136.00	3,686.04
ROUTINE NURSERY	7	0	5,928.24	2,052.30
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	17,064.24	5,738.34
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	3,505.85	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	3,505.85	0.00
TOTAL ACCOMODATIONS	20	0	20,570.09	5,738.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,410.99	0.00
MED/SURG SUPPLY	9,504.10	0.00
LABORATORY-GENERAL	26,802.37	0.00
RADIOLOGY-DIAGNOSTIC	4,066.08	0.00
CT SCAN	0.00	19,666.86
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,024.88	0.00
IV THERAPY	4,015.59	0.00
OPERATING ROOM	12,276.48	0.00
LABOR/DELIVERY ROOM	25,363.79	0.00
RESPIRATORY SERVICES	193.60	0.00
ANESTHESIA	10,012.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,349.67	0.00
RECOVERY ROOM	8,415.70	0.00
LABORATORY PATHOLOGIC	3,942.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	784.08	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,551.18	0.00
AUDIOLOGY	339.40	0.00
CARDIOLOGY	1,333.66	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,141.82	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	163,528.56	19,666.86
TOTAL ACCOMODATIONS	20,570.09	5,738.34
TOTAL CHARGES	184,098.65	25,405.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,919,153.63	ADJUSTMENTS	1,078,095.27
COVERED CHARGES	20,892,750.13	CONTRACTUAL ALLOW	17,154,205.51
NON-COVERD CHARGES	2,026,403.50	TOTAL MEDICAID LIAB	3,738,544.62
		LESS: COB	5,610.88
		LESS: COPAYMENT	5,615.78
		REIMBURSEMENT	3,727,317.96
		ALL OTHER	3,512,644.95
		FEE SCHEDULE-LAB	158,525.65
		INJECTABLE DRUGS	56,147.36

TOTAL NUMBER OF CLAIMS 6,212

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	762,942.34	17,140.38
MED/SURG SUPPLY	1,088,497.40	43,104.57
LABORATORY-GENERAL	0.00	459.20
RADIOLOGY-DIAGNOSTIC	1,255,108.57	13,798.92
CT SCAN	2,108,502.95	192,143.11
PHYSICAL THERAPY	35,660.09	6,126.33
EKG/ECG	276,576.68	0.00
IV THERAPY	116,140.47	3,857.22
OPERATING ROOM	734,914.40	267,983.50
LABOR/DELIVERY ROOM	27,423.95	1,753.08
RESPIRATORY SERVICES	77,192.34	10,819.10
ANESTHESIA	720,365.25	0.00
GI SERVICES	480,913.77	32,678.66
EMERGENCY ROOM	4,375,708.30	44,733.91
RECOVERY ROOM	161,103.55	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	147,641.39	0.00
OCCUPATIONAL THERAPY	10,224.72	1,913.73
SPEECH PATHOLOGY	4,706.90	5,177.60
RENAL DIALYSIS	0.00	6,368.85
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,880.27	11,467.29
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,739,650.82	128,138.22
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24,564.89	35,495.14
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	183,884.28	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	128,944.99	17,663.57
AMBULATORY SURGERY	11,908.56	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	279,146.74	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	226,563.44	6,368.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	167,829.68	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,579.76	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,104,488.31	816,679.64
MRI SERVICES	719,995.77	35,917.64
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	3,484.00
INJECTABLE DRUGS	909,689.55	322,956.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	174.24

TOTAL ANCILLARY	20,892,750.13	2,026,403.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,892,750.13	2,026,403.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3637	4410259064942	07/23/10 - 07/23/10	09/27/10	0.00	8.47	0.00	0.00	0.00
3300	4410259078005	07/25/10 - 07/25/10	09/27/10	0.00	165.77	0.00	0.00	0.00
TOTAL				0.00	174.24	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,514.24	ADJUSTMENTS	0.00
COVERED CHARGES	58,881.66	CONTRACTUAL ALLOW	8,398.87
NON-COVERD CHARGES	19,632.58	TOTAL MEDICAID LIAB	50,482.79
		LESS: COB	50,479.79
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	238.82	0.00
MED/SURG SUPPLY	1,244.70	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,572.39	0.00
CT SCAN	4,163.37	7,948.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,028.05	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	185.01	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,344.04	2,450.38
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	141.57
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,420.91	3,274.62
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	294.49	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,318.20	5,088.91
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,071.68	728.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	58,881.66	19,632.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,881.66	19,632.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,478,295.91	ADJUSTMENTS	9,809.06
COVERED CHARGES	1,351,427.80	CONTRACTUAL ALLOW	1,304,344.61
NON-COVERD CHARGES	126,868.11	TOTAL MEDICAID LIAB	47,083.19
		LESS: COB	0.00
		LESS: COPAYMENT	1,680.17
		REIMBURSEMENT	45,403.02

TOTAL NUMBER OF CLAIMS 849

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,944.52	263.53
MED/SURG SUPPLY	21,500.16	1,265.78
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,888.85	431.24
CT SCAN	45,761.34	33,142.14
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,366.81	0.00
IV THERAPY	1,377.57	0.00
OPERATING ROOM	972.96	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,152.84	337.95
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	730,195.40	1,191.01
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	155.73
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	53,258.45	11,302.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,551.18	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,333.66	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,418.73	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,810.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	315,266.34	69,047.59
MRI SERVICES	19,362.06	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	37,266.77	9,730.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,351,427.80	126,868.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,351,427.80	126,868.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,593.70	ADJUSTMENTS	0.00
COVERED CHARGES	2,505.91	CONTRACTUAL ALLOW	1,439.13
NON-COVERD CHARGES	1,087.79	TOTAL MEDICAID LIAB	1,066.78
		LESS: COB	1,063.78
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
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PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	542.08	31.46
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,939.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	1,056.33			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,505.91	1,087.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,505.91	1,087.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,887,885.91	ADJUSTMENTS	168,704.30
COVERED CHARGES	4,406,204.99	CONTRACTUAL ALLOW	3,769,864.06
NON-COVERD CHARGES	481,680.92	TOTAL MEDICAID LIAB	636,340.93
		LESS: COB	4,640.03
		LESS: COPAYMENT	890.67
		REIMBURSEMENT	630,810.23

TOTAL NUMBER OF CLAIMS 127

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/10 THROUGH 05/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230,990.95	6,689.93
MED/SURG SUPPLY	620,024.86	122,379.82
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,021.77	1,134.01
CT SCAN	104,521.23	0.00
PHYSICAL THERAPY	0.00	1,253.79
EKG/ECG	38,293.13	0.00
IV THERAPY	15,390.92	0.00
OPERATING ROOM	1,169,212.34	122,457.04
LABOR/DELIVERY ROOM	10,509.35	0.00
RESPIRATORY SERVICES	8,757.43	0.00
ANESTHESIA	526,328.00	0.00
GI SERVICES	2,422.41	0.00
EMERGENCY ROOM	94,357.52	951.79
RECOVERY ROOM	148,692.55	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	349,588.87	1,107.39
OCCUPATIONAL THERAPY	0.00	463.19
SPEECH PATHOLOGY	0.00	1,236.50
RENAL DIALYSIS	0.00	4,245.90
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,967.74	933.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	22,848.07	5,269.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,168.86	1,570.58
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	74,650.57	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	44,715.25	11,962.15
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,835.45	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	73,447.77	6,368.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,253.96	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	329,592.14	58,906.34
MRI SERVICES	16,315.40	8,558.32
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,742.00
INJECTABLE DRUGS	458,298.45	124,450.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,406,204.99	481,680.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,406,204.99	481,680.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH FULTON MEDICAL CENTER
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/10	THROUGH	05/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,494,473.02	ADJUSTMENTS	2,347,118.67
COVERED CHARGES	25,564,152.52	CONTRACTUAL ALLOW	14,679,052.73
NON-COVERD CHARGES	1,930,320.50	TOTAL MEDICAID LIAB	10,885,099.79
		LESS: COB	100,004.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,785,094.95

TOTAL NUMBER OF ADMISSIONS 1,568

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,791	2	3,869,320.00	1,738,024.00
ROUTINE NURSERY	362	0	186,510.00	14,830.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	10	0.00	0.00
TOTAL ROUTINE	7,153	12	4,055,830.00	1,752,854.00
SPECIAL CARE SERVICES				
CCU	126	0	170,608.00	0.00
ICU	731	0	998,165.25	0.00
NICU	2	0	2,480.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	859	0	1,171,253.25	0.00
TOTAL ACCOMODATIONS	8,012	12	5,227,083.25	1,752,854.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,521,499.25	2,561.00
MED/SURG SUPPLY	2,960,688.75	67,398.25
LABORATORY-GENERAL	2,363,972.22	5,238.75
RADIOLOGY-DIAGNOSTIC	316,440.70	0.00
CT SCAN	868,567.00	2,630.75
PHYSICAL THERAPY	108,055.25	0.00
EKG/ECG	387,874.00	0.00
IV THERAPY	61,725.50	3,086.50
OPERATING ROOM	969,502.87	0.00
LABOR/DELIVERY ROOM	179,986.50	0.00
RESPIRATORY SERVICES	1,048,311.25	5,232.50
ANESTHESIA	76,211.25	0.00
GI SERVICES	2,830.50	0.00
EMERGENCY ROOM	355,787.00	3,287.00
RECOVERY ROOM	148,094.11	0.00
LABORATORY PATHOLOGIC	71,727.25	0.00
RADIOLOGY THERAPEUTIC	85,458.25	376.75
OCCUPATIONAL THERAPY	23,673.75	0.00
SPEECH PATHOLOGY	28,315.05	0.00
RENAL DIALYSIS	84,160.25	4,420.75
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,739.75	1,591.00
PSYCHIATRIC SERVICES	395,180.25	20,367.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	105,576.25	13,333.50
BLOOD	197,329.00	0.00
BLOOD STORAGE & PRO.	174,500.25	21,442.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	50,948.75	0.00
AUDIOLOGY	12,283.50	0.00
CARDIOLOGY	671,016.25	0.00
AMBULATORY SURGERY	89,939.04	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,190.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	420,320.00	19,389.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	70,610.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	21,290.25	3,212.00
OTHER THERAPEUTIC SVC	32,214.00	3,672.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	238,922.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,162,128.78	226.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,337,069.27	177,466.50
TOTAL ACCOMODATIONS	5,227,083.25	1,752,854.00
TOTAL CHARGES	25,564,152.52	1,930,320.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	349,975.00	ADJUSTMENTS	0.00
COVERED CHARGES	341,537.10	CONTRACTUAL ALLOW	81,059.65
NON-COVERD CHARGES	8,437.90	TOTAL MEDICAID LIAB	260,477.45
		LESS: COB	260,477.45
		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	77	0	43,890.00	5,730.00
ROUTINE NURSERY	5	0	2,570.00	190.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	82	0	46,460.00	5,920.00
SPECIAL CARE SERVICES				
CCU	9	0	12,240.00	0.00
ICU	16	0	21,760.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	25	0	34,000.00	0.00
TOTAL ACCOMODATIONS	107	0	80,460.00	5,920.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,225.75	27.75
MED/SURG SUPPLY	37,263.10	570.40
LABORATORY-GENERAL	31,795.00	440.75
RADIOLOGY-DIAGNOSTIC	2,582.50	0.00
CT SCAN	4,569.75	0.00
PHYSICAL THERAPY	1,179.25	0.00
EKG/ECG	3,072.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,131.50	0.00
LABOR/DELIVERY ROOM	7,686.50	0.00
RESPIRATORY SERVICES	14,697.25	0.00
ANESTHESIA	326.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,092.50	163.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	557.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	695.00	0.00
SPEECH PATHOLOGY	1,068.00	0.00
RENAL DIALYSIS	4,800.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	34.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,645.25	0.00
BLOOD	7,198.75	0.00
BLOOD STORAGE & PRO.	2,185.00	1,062.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	164.50	0.00
CARDIOLOGY	2,132.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	407.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,399.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,829.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	303.50	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,921.50	0.00
PROFESSIONAL FEES	0.00	253.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,115.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	261,077.10	2,517.90
TOTAL ACCOMODATIONS	80,460.00	5,920.00
TOTAL CHARGES	341,537.10	8,437.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,461,064.38	ADJUSTMENTS	533,707.21
COVERED CHARGES	9,293,339.95	CONTRACTUAL ALLOW	5,731,875.02
NON-COVERD CHARGES	1,167,724.43	TOTAL MEDICAID LIAB	3,561,464.93
		LESS: COB	2,676.84
		LESS: COPAYMENT	9,744.00
		REIMBURSEMENT	3,549,044.09
		ALL OTHER	3,170,675.89
		FEE SCHEDULE-LAB	234,526.23
		INJECTABLE DRUGS	143,841.97

TOTAL NUMBER OF CLAIMS 8,028

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	823,306.75	9,060.25
MED/SURG SUPPLY	863,706.75	150,150.25
LABORATORY-GENERAL	0.00	101.00
RADIOLOGY-DIAGNOSTIC	372,300.00	15,029.25
CT SCAN	1,064,239.25	127,537.25
PHYSICAL THERAPY	0.00	1,151.50
EKG/ECG	127,926.50	2,129.00
IV THERAPY	150,086.25	4,188.25
OPERATING ROOM	673,828.32	180,016.74
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	74,355.50	8,292.00
ANESTHESIA	118,762.16	882.50
GI SERVICES	6,006.75	1,063.42
EMERGENCY ROOM	1,017,049.50	12,443.25
RECOVERY ROOM	220,962.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	263,507.50	0.00
OCCUPATIONAL THERAPY	0.00	279.50
SPEECH PATHOLOGY	0.00	1,875.25
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,335.00	4,010.00
PSYCHIATRIC SERVICES	266,364.75	13,023.75
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	313,628.25	40,143.25
BLOOD	62,356.50	0.00
BLOOD STORAGE & PRO.	5,963.00	44,242.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	97,705.50	1,186.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	144,710.50	103,296.00
AMBULATORY SURGERY	129,208.39	27,742.27
OSTEOPATHIC SERVICES	0.00	0.00
E E G	46,424.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	377,510.50	11,753.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	72,899.00	770.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,235.00	5,497.75
OTHER THERAPEUTIC SVC	204.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,109,940.17	178,192.25
MRI SERVICES	182,411.75	8,744.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	660,405.71	214,923.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,293,339.95	1,167,724.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,293,339.95	1,167,724.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,605.23	ADJUSTMENTS	0.00
COVERED CHARGES	15,969.98	CONTRACTUAL ALLOW	7,748.69
NON-COVERD CHARGES	6,635.25	TOTAL MEDICAID LIAB	8,221.29
		LESS: COB	8,212.29
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,961.75	3.25
MED/SURG SUPPLY	955.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	331.50	0.00
CT SCAN	0.00	5,859.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	417.75	0.00
IV THERAPY	2,473.50	81.75
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	3,361.75	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 SERVICE	458.75	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/OBSERV. RM	3,958.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	398.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,577.75	268.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	473.98	24.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,969.98	6,635.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,969.98	6,635.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	612,387.25	ADJUSTMENTS	1,709.08
COVERED CHARGES	589,403.75	CONTRACTUAL ALLOW	529,268.25
NON-COVERD CHARGES	22,983.50	TOTAL MEDICAID LIAB	60,135.50
		LESS: COB	0.00
		LESS: COPAYMENT	1,908.09
		REIMBURSEMENT	58,227.41
		TOTAL NUMBER OF CLAIMS	1,075

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,353.50	226.50
MED/SURG SUPPLY	38,689.75	129.75
LABORATORY-GENERAL	0.00	10.75
RADIOLOGY-DIAGNOSTIC	30,765.00	150.25
CT SCAN	51,554.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,722.00	0.00
IV THERAPY	12,856.75	700.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,124.00	164.50
ANESTHESIA	0.00	0.00
GI SERVICES	283.25	0.00
EMERGENCY ROOM	266,399.00	2,041.75
RECOVERY ROOM	422.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	39.50	183.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,286.00	1,693.75
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	1,066.00	0.00
AMBULATORY SURGERY	1,791.50	1,534.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	407.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,926.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,140.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	99,451.00	14,504.00
MRI SERVICES	1,766.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,360.00	1,644.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	589,403.75	22,983.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	589,403.75	22,983.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,361.50	ADJUSTMENTS	0.00
COVERED CHARGES	3,340.00	CONTRACTUAL ALLOW	672.66
NON-COVERD CHARGES	21.50	TOTAL MEDICAID LIAB	2,667.34
		LESS: COB	2,667.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	70.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	756.75	21.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	708.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	598.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	345.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	779.25	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,340.00	21.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,340.00	21.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,436,682.70	ADJUSTMENTS	115,127.15
COVERED CHARGES	4,192,372.95	CONTRACTUAL ALLOW	3,253,958.67
NON-COVERD CHARGES	244,309.75	TOTAL MEDICAID LIAB	938,414.28
		LESS: COB	0.00
		LESS: COPAYMENT	2,496.81
		REIMBURSEMENT	935,917.47

TOTAL NUMBER OF CLAIMS 186

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	825,162.25	755.00
MED/SURG SUPPLY	309,752.75	1,945.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,285.25	4,237.50
CT SCAN	71,875.25	6,993.25
PHYSICAL THERAPY	0.00	228.00
EKG/ECG	9,193.25	139.50
IV THERAPY	107,900.00	327.00
OPERATING ROOM	115,525.50	915.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	101,147.25	0.00
ANESTHESIA	7,112.50	176.50
GI SERVICES	1,415.25	0.00
EMERGENCY ROOM	5,868.50	0.00
RECOVERY ROOM	28,851.05	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	526,279.50	2,023.50
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	294.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	32,919.25	0.00
BLOOD	43,069.50	0.00
BLOOD STORAGE & PRO.	1,599.50	14,151.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,375.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	43,283.00	74,320.00
AMBULATORY SURGERY	1,534.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	407.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	96,300.00	25,824.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,946.00	385.25
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	78.50	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	52,477.50	5,602.50
MRI SERVICES	5,919.75	2,649.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,758,094.40	103,341.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,192,372.95	244,309.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,192,372.95	244,309.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER
PO BOX 70
VALDOSTA,GA 31603-0070

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,054,766.99	ADJUSTMENTS	31,053.47
COVERED CHARGES	13,900,689.74	CONTRACTUAL ALLOW	9,105,455.09
NON-COVERD CHARGES	1,154,077.25	TOTAL MEDICAID LIAB	4,795,234.65
		LESS: COB	52,037.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,743,197.25

TOTAL NUMBER OF ADMISSIONS 621

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,844	0	2,267,148.50	859,425.00
ROUTINE NURSERY	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	3,844	0	2,267,148.50	859,425.00
SPECIAL CARE SERVICES				
CCU	232	0	307,400.00	0.00
ICU	266	0	352,450.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	498	0	659,850.00	0.00
TOTAL ACCOMODATIONS	4,342	0	2,926,998.50	859,425.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,612,685.01	0.00
MED/SURG SUPPLY	2,148,034.00	1,135.00
LABORATORY-GENERAL	1,840,207.00	0.00
RADIOLOGY-DIAGNOSTIC	171,007.00	0.00
CT SCAN	327,193.75	0.00
PHYSICAL THERAPY	115,307.58	0.00
EKG/ECG	275,420.50	0.00
IV THERAPY	26,072.25	0.00
OPERATING ROOM	980,170.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	677,936.25	0.00
ANESTHESIA	264,345.25	0.00
GI SERVICES	123,250.00	0.00
EMERGENCY ROOM	195,228.00	0.00
RECOVERY ROOM	56,509.50	0.00
LABORATORY PATHOLOGIC	132,376.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	44,774.25	0.00
SPEECH PATHOLOGY	20,740.50	0.00
RENAL DIALYSIS	91,420.25	82,660.25
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	137.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	30,560.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	123,926.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,736.75	5,023.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	459,774.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,755.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	50,328.83	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	37,674.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	114,294.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	205,696.25
INJECTABLE DRUGS	13,964.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,973,691.24	294,652.25
TOTAL ACCOMODATIONS	2,926,998.50	859,425.00
TOTAL CHARGES	13,900,689.74	1,154,077.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	225,516.27	ADJUSTMENTS	0.00
COVERED CHARGES	203,776.27	CONTRACTUAL ALLOW	118,610.04
NON-COVERD CHARGES	21,740.00	TOTAL MEDICAID LIAB	85,166.23
		LESS: COB	85,166.23
		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	45	0	26,550.00	15,500.00
ROUTINE NURSERY	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	26,550.00	15,500.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	13	0	17,225.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	13	0	17,225.00	0.00
TOTAL ACCOMODATIONS	58	0	43,775.00	15,500.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,140.52	0.00
MED/SURG SUPPLY	13,490.75	0.00
LABORATORY-GENERAL	28,952.50	0.00
RADIOLOGY-DIAGNOSTIC	1,639.50	0.00
CT SCAN	1,053.00	0.00
PHYSICAL THERAPY	1,993.00	0.00
EKG/ECG	1,020.25	0.00
IV THERAPY	529.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,006.75	0.00
ANESTHESIA	617.50	0.00
GI SERVICES	5,909.25	0.00
EMERGENCY ROOM	1,026.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	6,269.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,333.00	0.00
SPEECH PATHOLOGY	1,161.00	0.00
RENAL DIALYSIS	0.00	6,240.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	215.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,384.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,907.50	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/OBSERV. RM	1,028.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	516.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,514.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	292.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	160,001.27	6,240.00
TOTAL ACCOMODATIONS	43,775.00	15,500.00
TOTAL CHARGES	203,776.27	21,740.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,231,956.96	ADJUSTMENTS	66,914.00
COVERED CHARGES	4,172,696.61	CONTRACTUAL ALLOW	3,149,057.82
NON-COVERD CHARGES	1,059,260.35	TOTAL MEDICAID LIAB	1,023,638.79
		LESS: COB	17,690.45
		LESS: COPAYMENT	3,979.81
		REIMBURSEMENT	1,001,968.53
		ALL OTHER	934,755.46
		FEE SCHEDULE-LAB	67,102.88
		INJECTABLE DRUGS	110.19

TOTAL NUMBER OF CLAIMS 2,913

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	366,712.06	1,723.19
MED/SURG SUPPLY	577,708.50	1,749.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	246,093.00	4,455.25
CT SCAN	286,826.75	47,334.00
PHYSICAL THERAPY	45,222.75	7,482.75
EKG/ECG	97,599.50	4,732.75
IV THERAPY	34,708.25	0.00
OPERATING ROOM	352,000.02	275,688.73
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31,245.25	9,243.75
ANESTHESIA	122,839.50	351.00
GI SERVICES	35,513.42	13,047.63
EMERGENCY ROOM	654,533.00	8,323.00
RECOVERY ROOM	51,420.50	476.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	297.25	0.00
OCCUPATIONAL THERAPY	25,032.75	7,469.50
SPEECH PATHOLOGY	1,158.00	2,697.25
RENAL DIALYSIS	0.00	1,277.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65,044.75	3,847.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,833.50	0.00
OTHER IMAGING SERVICE	37,163.50	742.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,716.75	2,872.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	69,990.75	16,087.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	186,392.75	446,287.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,708.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	33,166.61	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	28,930.50	1,384.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	610,838.50	126,980.35
MRI SERVICES	158,281.25	20,448.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	1,571.00	1,101.00
INJECTABLE DRUGS	1,148.25	53,456.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,172,696.61	1,059,260.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,172,696.61	1,059,260.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	116,489.82	ADJUSTMENTS	0.00
COVERED CHARGES	79,533.91	CONTRACTUAL ALLOW	38,038.84
NON-COVERD CHARGES	36,955.91	TOTAL MEDICAID LIAB	41,495.07
		LESS: COB	41,406.63
		LESS: COPAYMENT	88.44
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,444.17	899.66
MED/SURG SUPPLY	4,022.25	3,302.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,971.50	121.25
CT SCAN	7,194.75	4,991.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,488.75	0.00
IV THERAPY	264.75	0.00
OPERATING ROOM	17,035.00	12,761.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,618.50	1,138.50
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,663.00	52.00
RECOVERY ROOM	1,078.50	602.50
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	1,411.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	717.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,076.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,195.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	6,815.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	491.49	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,775.75	215.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,084.00	5,134.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1.00	923.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	79,533.91	36,955.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,533.91	36,955.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	331,030.82	ADJUSTMENTS	211.76
COVERED CHARGES	320,802.32	CONTRACTUAL ALLOW	289,587.80
NON-COVERD CHARGES	10,228.50	TOTAL MEDICAID LIAB	31,214.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,308.00
		REIMBURSEMENT	29,906.52

TOTAL NUMBER OF CLAIMS 558

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,625.01	0.00
MED/SURG SUPPLY	15,692.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,462.00	0.00
CT SCAN	20,127.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,318.75	0.00
IV THERAPY	2,900.25	0.00
OPERATING ROOM	153.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	782.25	255.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	170,240.50	515.50
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 SERVICE	952.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,461.25	232.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	383.56	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	726.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	64,937.50	9,126.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40.25	100.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	320,802.32	10,228.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320,802.32	10,228.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,256.79	ADJUSTMENTS	0.00
COVERED CHARGES	4,614.29	CONTRACTUAL ALLOW	2,706.71
NON-COVERD CHARGES	642.50	TOTAL MEDICAID LIAB	1,907.58
		LESS: COB	1,898.58
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,594.25	642.50
EKG/ECG	145.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,574.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,614.29	642.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,614.29	642.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,235,733.53	ADJUSTMENTS	5,082.13
COVERED CHARGES	1,084,605.03	CONTRACTUAL ALLOW	944,060.30
NON-COVERD CHARGES	151,128.50	TOTAL MEDICAID LIAB	140,544.73
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	140,391.73

TOTAL NUMBER OF CLAIMS 28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,415.41	100.00
MED/SURG SUPPLY	504,243.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,526.25	2,787.75
CT SCAN	5,098.50	0.00
PHYSICAL THERAPY	0.00	295.25
EKG/ECG	2,915.00	2,151.25
IV THERAPY	1,329.00	0.00
OPERATING ROOM	373,975.25	19,943.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	119.75	0.00
ANESTHESIA	33,812.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,980.75	156.00
RECOVERY ROOM	9,863.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	295.25
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	190.00	104.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	544.50	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	22,661.00	119,192.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,617.87	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,313.75	2,471.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,632.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,084,605.03	151,128.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,084,605.03	151,128.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
PO BOX 84022
COLUMBUS,GA 31908-4022

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,147,792.48	ADJUSTMENTS	316,954.49
COVERED CHARGES	5,056,774.73	CONTRACTUAL ALLOW	3,647,749.85
NON-COVERD CHARGES	91,017.75	TOTAL MEDICAID LIAB	1,409,024.88
		LESS: COB	11,188.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,397,836.33

TOTAL NUMBER OF ADMISSIONS 170

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	362	0	388,308.00	30,271.00
ROUTINE NURSERY	83	0	50,807.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	445	0	439,115.00	30,271.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	443	0	684,314.00	0.00
NICU	2	0	3,756.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	445	0	688,070.00	0.00
TOTAL ACCOMODATIONS	890	0	1,127,185.00	30,271.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	797,974.30	0.00
MED/SURG SUPPLY	703,143.39	1,115.03
LABORATORY-GENERAL	325,554.30	0.00
RADIOLOGY-DIAGNOSTIC	134,413.68	0.00
CT SCAN	80,269.62	8,522.22
PHYSICAL THERAPY	30,964.20	0.00
EKG/ECG	15,934.34	0.00
IV THERAPY	1,917.55	0.00
OPERATING ROOM	561,701.55	0.00
LABOR/DELIVERY ROOM	151,046.50	0.00
RESPIRATORY SERVICES	211,471.51	15,230.83
ANESTHESIA	158,425.27	0.00
GI SERVICES	26,297.17	0.00
EMERGENCY ROOM	227,677.41	0.00
RECOVERY ROOM	85,477.20	0.00
LABORATORY PATHOLOGIC	26,460.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	498.28	0.00
SPEECH PATHOLOGY	990.52	0.00
RENAL DIALYSIS	128,761.36	33,701.06
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	427.64	334.85
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,208.72	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	82,177.21	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,792.71	1,842.76
AUDIOLOGY	15,283.87	0.00
CARDIOLOGY	84,275.29	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	546.78	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,114.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,891.18	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	9,409.32	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,484.12	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,929,589.73	60,746.75
TOTAL ACCOMODATIONS	1,127,185.00	30,271.00
TOTAL CHARGES	5,056,774.73	91,017.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	349,701.62	ADJUSTMENTS	0.00
COVERED CHARGES	345,697.62	CONTRACTUAL ALLOW	150,733.68
NON-COVERD CHARGES	4,004.00	TOTAL MEDICAID LIAB	194,963.94
		LESS: COB	194,963.94
		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	39	0	42,720.00	4,004.00
ROUTINE NURSERY	3	0	1,749.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	42	0	44,469.00	4,004.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	14	0	28,686.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	28,686.00	0.00
TOTAL ACCOMODATIONS	56	0	73,155.00	4,004.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,767.77	0.00
MED/SURG SUPPLY	101,045.13	0.00
LABORATORY-GENERAL	7,475.97	0.00
RADIOLOGY-DIAGNOSTIC	1,874.88	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,588.81	0.00
EKG/ECG	189.35	0.00
IV THERAPY	815.30	0.00
OPERATING ROOM	16,324.02	0.00
LABOR/DELIVERY ROOM	40,146.00	0.00
RESPIRATORY SERVICES	34,109.07	0.00
ANESTHESIA	5,594.10	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,141.65	0.00
RECOVERY ROOM	2,556.02	0.00
LABORATORY PATHOLOGIC	239.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	166.36	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,604.40	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	876.29	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,804.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,223.14	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	272,542.62	0.00
TOTAL ACCOMODATIONS	73,155.00	4,004.00
TOTAL CHARGES	345,697.62	4,004.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,951,636.92	ADJUSTMENTS	379,046.39
COVERED CHARGES	3,674,406.75	CONTRACTUAL ALLOW	2,885,283.94
NON-COVERD CHARGES	277,230.17	TOTAL MEDICAID LIAB	789,122.81
		LESS: COB	6,131.74
		LESS: COPAYMENT	2,565.00
		REIMBURSEMENT	780,426.07
		ALL OTHER	727,538.57
		FEE SCHEDULE-LAB	48,498.37
		INJECTABLE DRUGS	4,389.13

TOTAL NUMBER OF CLAIMS 1,775

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,400.69	13,722.64
MED/SURG SUPPLY	142,795.25	10,827.84
LABORATORY-GENERAL	0.00	48.87
RADIOLOGY-DIAGNOSTIC	99,771.28	1,062.35
CT SCAN	104,819.78	31,705.75
PHYSICAL THERAPY	4,355.98	2,724.60
EKG/ECG	20,426.60	171.74
IV THERAPY	153,544.43	518.86
OPERATING ROOM	383,547.36	47,166.38
LABOR/DELIVERY ROOM	732.00	0.00
RESPIRATORY SERVICES	75,203.25	1,664.98
ANESTHESIA	351,641.30	0.00
GI SERVICES	339,993.75	61,671.69
EMERGENCY ROOM	691,240.90	2,968.01
RECOVERY ROOM	272,941.84	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	392.68	883.53
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,008.76	991.35
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	79,337.62	755.06
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,325.91	2,433.82
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,984.92	2,343.29
AUDIOLOGY	0.00	0.00
CARDIOLOGY	39,666.79	33,223.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	245,522.30	872.30

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	126,746.02	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	126.56
OTHER THERAPEUTIC SVC	45,244.62	452.06
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	304,827.20	30,346.00
MRI SERVICES	15,525.17	3,775.06
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80,410.35	26,709.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,674,406.75	277,165.37
TOTAL ACCOMODATIONS	0.00	64.80
TOTAL CHARGES	3,674,406.75	277,230.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	71,754.31	ADJUSTMENTS	0.00
COVERED CHARGES	58,361.17	CONTRACTUAL ALLOW	33,452.08
NON-COVERD CHARGES	13,393.14	TOTAL MEDICAID LIAB	24,909.09
		LESS: COB	24,885.09
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252.71	1,476.92
MED/SURG SUPPLY	483.85	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,923.23	0.00
CT SCAN	0.00	895.23
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	737.20	0.00
IV THERAPY	6,363.30	0.00
OPERATING ROOM	1,329.00	0.00
LABOR/DELIVERY ROOM	357.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	4,722.42	0.00
GI SERVICES	1,791.93	8,320.63
EMERGENCY ROOM	15,753.58	0.00
RECOVERY ROOM	3,836.51	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	263.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	429.49	451.18
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,487.77	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,115.66	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,811.04	986.79
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,703.48	1,262.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	58,361.17	13,393.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,361.17	13,393.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	153,066.65	ADJUSTMENTS	933.92
COVERED CHARGES	150,617.41	CONTRACTUAL ALLOW	138,534.37
NON-COVERD CHARGES	2,449.24	TOTAL MEDICAID LIAB	12,083.04
		LESS: COB	43.00
		LESS: COPAYMENT	384.00
		REIMBURSEMENT	11,656.04

TOTAL NUMBER OF CLAIMS 216

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	852.61	287.77
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,457.49	0.00
CT SCAN	4,182.20	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	882.85	0.00
IV THERAPY	9,612.16	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	257.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	115,421.14	596.35
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	215.98
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	589.65	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,793.14	980.98
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,568.57	368.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	150,617.41	2,449.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	150,617.41	2,449.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	790.16	ADJUSTMENTS	0.00
COVERED CHARGES	790.16	CONTRACTUAL ALLOW	495.27
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	294.89
		LESS: COB	294.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	790.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	790.16	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	790.16	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	556,373.48	ADJUSTMENTS	71,057.44
COVERED CHARGES	507,691.42	CONTRACTUAL ALLOW	416,062.05
NON-COVERD CHARGES	48,682.06	TOTAL MEDICAID LIAB	91,629.37
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	91,464.37

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,531.49	880.97
MED/SURG SUPPLY	75,523.98	12,490.42
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,194.28	14,497.04
CT SCAN	0.00	1,689.12
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	367.52	180.33
IV THERAPY	501.58	0.00
OPERATING ROOM	137,698.24	4,724.82
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	71,955.87	0.00
ANESTHESIA	53,093.97	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,696.63	0.00
RECOVERY ROOM	21,300.21	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	605.81	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	802.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,193.28	10,961.38
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,293.04	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,091.02	1,307.90
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,842.30	1,950.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	507,691.42	48,682.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	507,691.42	48,682.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AUGUSTA HOSPITAL LLC
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,928,604.55	ADJUSTMENTS	1,431,106.53
COVERED CHARGES	26,604,462.09	CONTRACTUAL ALLOW	19,806,030.07
NON-COVERD CHARGES	324,142.46	TOTAL MEDICAID LIAB	6,798,432.02
		LESS: COB	90,970.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,707,461.59

TOTAL NUMBER OF ADMISSIONS 467

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,791	0	1,479,075.00	7,208.00
ROUTINE NURSERY	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	1,791	0	1,479,075.00	7,208.00
SPECIAL CARE SERVICES				
CCU	276	0	771,996.00	0.00
ICU	1,810	3	3,293,168.00	3,354.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,086	3	4,065,164.00	3,354.00
TOTAL ACCOMODATIONS	3,877	3	5,544,239.00	10,562.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,541,704.68	7.00
MED/SURG SUPPLY	3,740,667.71	34,575.46
LABORATORY-GENERAL	2,005,371.70	6,502.00
RADIOLOGY-DIAGNOSTIC	910,586.00	0.00
CT SCAN	792,180.00	17,001.00
PHYSICAL THERAPY	293,687.00	0.00
EKG/ECG	65,345.00	0.00
IV THERAPY	81,978.00	358.00
OPERATING ROOM	2,415,239.00	8,859.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,690,954.00	1,369.00
ANESTHESIA	488,356.00	0.00
GI SERVICES	66,307.00	0.00
EMERGENCY ROOM	260,846.00	0.00
RECOVERY ROOM	296,405.00	0.00
LABORATORY PATHOLOGIC	80,273.00	0.00
RADIOLOGY THERAPEUTIC	1,887.00	0.00
OCCUPATIONAL THERAPY	136,220.00	0.00
SPEECH PATHOLOGY	124,688.00	0.00
RENAL DIALYSIS	163,974.00	41,943.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	100,770.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	795,714.00	58,963.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,190.00	67,057.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	528,668.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	114,090.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	82,366.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	126,717.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	74,602.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	314,499.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	2,344.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,785,540.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,060,223.09	313,580.46
TOTAL ACCOMODATIONS	5,544,239.00	10,562.00
TOTAL CHARGES	26,604,462.09	324,142.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,915.00	ADJUSTMENTS	0.00
COVERED CHARGES	110,915.00	CONTRACTUAL ALLOW	62,378.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	48,536.32
		LESS: COB	48,536.32
		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	10	0	8,240.00	0.00
ROUTINE NURSERY	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	8,240.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	9,499.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	9,499.00	0.00
TOTAL ACCOMODATIONS	17	0	17,739.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,994.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,800.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,293.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,707.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,039.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	605.00	0.00	MRI SERVICES	1,791.00	0.00
IV THERAPY	866.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,739.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,738.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,528.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,167.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	263.00	0.00	INJECTABLE DRUGS	19,590.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	637.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	770.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,805.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,176.00	0.00
TOTAL ACCOMODATIONS	17,739.00	0.00
TOTAL CHARGES	110,915.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,362,351.59	ADJUSTMENTS	375,136.62
COVERED CHARGES	4,754,736.44	CONTRACTUAL ALLOW	3,731,807.26
NON-COVERD CHARGES	607,615.15	TOTAL MEDICAID LIAB	1,022,929.18
		LESS: COB	9,337.08
		LESS: COPAYMENT	2,223.00
		REIMBURSEMENT	1,011,369.10
		ALL OTHER	935,643.55
		FEE SCHEDULE-LAB	65,987.18
		INJECTABLE DRUGS	9,738.37

TOTAL NUMBER OF CLAIMS 1,869

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,393.00	50,023.00
MED/SURG SUPPLY	379,231.30	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	406,690.00	22,777.00
CT SCAN	512,342.00	49,371.00
PHYSICAL THERAPY	72,856.00	15,673.00
EKG/ECG	39,045.00	0.00
IV THERAPY	130,153.00	7,379.00
OPERATING ROOM	626,579.96	111,694.04
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,226.00	124.00
ANESTHESIA	167,259.00	533.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	621,961.34	3,066.66
RECOVERY ROOM	300,568.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	6,194.00	0.00
OCCUPATIONAL THERAPY	7,969.00	2,223.00
SPEECH PATHOLOGY	0.00	735.00
RENAL DIALYSIS	0.00	1,353.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	120.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	67,518.00	2,476.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,366.00	4,688.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	54,632.00	34,374.00
AUDIOLOGY	97,696.00	9,379.00
CARDIOLOGY	323,219.55	143,392.45
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,731.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	33,783.29	38,325.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	34,063.00	2,412.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	378,257.00	67,572.00
MRI SERVICES	87,321.00	8,057.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	130,562.00	31,988.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,754,736.44	607,615.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,754,736.44	607,615.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	133,918.00	ADJUSTMENTS	0.00
COVERED CHARGES	96,254.50	CONTRACTUAL ALLOW	57,730.86
NON-COVERD CHARGES	37,663.50	TOTAL MEDICAID LIAB	38,523.64
		LESS: COB	38,493.64
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,649.00	1,587.00
MED/SURG SUPPLY	18,380.00	95.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,994.00	0.00
CT SCAN	15,619.00	7,245.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,089.00	0.00
IV THERAPY	4,205.00	300.00
OPERATING ROOM	0.00	3,986.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	124.00	0.00
ANESTHESIA	934.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,784.00	0.00
RECOVERY ROOM	7,884.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,482.00	922.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,531.50	20,813.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	997.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,436.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	1,206.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,982.00	1,407.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,164.00	102.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	96,254.50	37,663.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,254.50	37,663.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	214,442.00	ADJUSTMENTS	1,718.08
COVERED CHARGES	193,952.00	CONTRACTUAL ALLOW	183,211.52
NON-COVERD CHARGES	20,490.00	TOTAL MEDICAID LIAB	10,740.48
		LESS: COB	0.00
		LESS: COPAYMENT	372.03
		REIMBURSEMENT	10,368.45
		TOTAL NUMBER OF CLAIMS	192

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,084.00	1,470.00	OTHER LAB	1,194.00	0.00
MED/SURG SUPPLY	192.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,350.00	478.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,081.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,652.00	3,158.00
EKG/ECG	1,936.00	0.00	MRI SERVICES	2,324.00	0.00
IV THERAPY	7,348.00	75.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	868.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,760.00	641.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,371.00	12,697.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,792.00	612.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,359.00			

TOTAL ANCILLARY	193,952.00	20,490.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	193,952.00	20,490.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,094.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,981.00	CONTRACTUAL ALLOW	7,555.21
NON-COVERD CHARGES	1,113.00	TOTAL MEDICAID LIAB	1,425.79
		LESS: COB	1,398.78
		LESS: COPAYMENT	27.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102.00	50.00	OTHER LAB	713.00	0.00
MED/SURG SUPPLY	24.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,247.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,278.00	816.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	795.00	15.00
EKG/ECG	121.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	358.00	150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	124.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,832.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	387.00	82.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,981.00	1,113.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,981.00	1,113.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,464,831.27	ADJUSTMENTS	43,241.86
COVERED CHARGES	1,344,706.41	CONTRACTUAL ALLOW	1,185,385.75
NON-COVERD CHARGES	120,124.86	TOTAL MEDICAID LIAB	159,320.66
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	159,161.66

TOTAL NUMBER OF CLAIMS 29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,515.00	10,087.00
MED/SURG SUPPLY	882,313.26	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,791.00	3,247.00
CT SCAN	1,793.00	0.00
PHYSICAL THERAPY	0.00	186.00
EKG/ECG	1,815.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	158,026.65	35,696.36
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,908.00	0.00
ANESTHESIA	47,168.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	87,990.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	999.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,672.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,279.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,243.50	60,614.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	2,193.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,421.00	530.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	2,533.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,460.00	1,502.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,311.00	2,537.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,344,706.41	120,124.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,344,706.41	120,124.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,286.00	ADJUSTMENTS	0.00
COVERED CHARGES	34,102.00	CONTRACTUAL ALLOW	17,327.80
NON-COVERD CHARGES	11,184.00	TOTAL MEDICAID LIAB	16,774.20
		LESS: COB	16,771.20
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	620.00	3,838.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,118.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	212.00	116.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,305.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,647.00	6,865.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	265.00			

TOTAL ANCILLARY	34,102.00	11,184.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,102.00	11,184.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,870,487.47	ADJUSTMENTS	911,120.47
COVERED CHARGES	20,209,406.68	CONTRACTUAL ALLOW	14,401,981.13
NON-COVERD CHARGES	661,080.79	TOTAL MEDICAID LIAB	5,807,425.55
		LESS: COB	203,331.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,604,094.01

TOTAL NUMBER OF ADMISSIONS 404

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,292	0	2,308,970.00	163,853.50
ROUTINE NURSERY	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	2,292	0	2,308,970.00	163,853.50
SPECIAL CARE SERVICES				
CCU	256	0	770,972.00	0.00
ICU	365	31	1,103,473.00	99,181.75
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	621	31	1,874,445.00	99,181.75
TOTAL ACCOMODATIONS	2,913	31	4,183,415.00	263,035.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,798,596.35	6,884.50
MED/SURG SUPPLY	3,198,135.55	278,492.50
LABORATORY-GENERAL	1,556,908.25	52.50
RADIOLOGY-DIAGNOSTIC	478,123.00	400.00
CT SCAN	812,263.50	550.00
PHYSICAL THERAPY	53,446.00	0.00
EKG/ECG	67,327.75	0.00
IV THERAPY	106,194.75	1,514.00
OPERATING ROOM	1,372,655.00	17,745.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,155,363.46	4,123.04
ANESTHESIA	129,063.25	0.00
GI SERVICES	86,887.00	0.00
EMERGENCY ROOM	293,961.50	1,235.25
RECOVERY ROOM	118,946.75	0.00
LABORATORY PATHOLOGIC	96,641.57	0.00
RADIOLOGY THERAPEUTIC	76,736.00	0.00
OCCUPATIONAL THERAPY	17,429.25	0.00
SPEECH PATHOLOGY	18,061.75	0.00
RENAL DIALYSIS	62,046.25	21,224.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,035.25
PSYCHIATRIC SERVICES	3,005.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	86,510.25	42,299.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	241,209.50	7,877.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	49,911.00	5,770.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	855,590.25	1,999.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,350.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,337.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	82,185.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	562.25	186.00
OTHER THERAPEUTIC SVC	0.00	2,894.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	181,102.75	0.00
PROFESSIONAL FEES	0.00	263.00
DURABLE MED. EQUIP.	0.00	1,612.75
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	440.00	0.00
HOME HEALTH SERVICES	0.00	887.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,025,991.68	398,045.54
TOTAL ACCOMODATIONS	4,183,415.00	263,035.25
TOTAL CHARGES	20,209,406.68	661,080.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,584,775.80	ADJUSTMENTS	29,184.82
COVERED CHARGES	3,365,770.38	CONTRACTUAL ALLOW	2,666,298.90
NON-COVERD CHARGES	1,219,005.42	TOTAL MEDICAID LIAB	699,471.48
		LESS: COB	6,837.20
		LESS: COPAYMENT	1,844.16
		REIMBURSEMENT	690,790.12
		ALL OTHER	603,072.60
		FEE SCHEDULE-LAB	45,357.26
		INJECTABLE DRUGS	42,360.26

TOTAL NUMBER OF CLAIMS 1,159

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153,709.25	9,091.75
MED/SURG SUPPLY	138,592.36	275,448.19
LABORATORY-GENERAL	0.00	125.25
RADIOLOGY-DIAGNOSTIC	154,318.00	20,334.50
CT SCAN	587,623.50	98,387.01
PHYSICAL THERAPY	0.00	726.25
EKG/ECG	33,935.00	0.00
IV THERAPY	139,557.00	11,478.75
OPERATING ROOM	182,015.33	96,068.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,163.50	0.00
ANESTHESIA	33,781.75	5,227.25
GI SERVICES	31,280.75	14,818.25
EMERGENCY ROOM	469,613.25	5,408.50
RECOVERY ROOM	91,113.50	1,548.50
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	135,800.75	50,627.25
OCCUPATIONAL THERAPY	0.00	284.50
SPEECH PATHOLOGY	0.00	535.25
RENAL DIALYSIS	0.00	4,204.25
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,900.00	436.00
PSYCHIATRIC SERVICES	370.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	142,949.25	18,823.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,051.25	4,863.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	59,340.50	20,143.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	132,518.25	291,687.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	64,202.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,878.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	191.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,192.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	354,509.64	64,086.80
MRI SERVICES	114,314.25	19,578.25
PROFESSIONAL FEES	0.00	79.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	290,041.05	203,801.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,365,770.38	1,219,005.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,365,770.38	1,219,005.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,078.75	ADJUSTMENTS	0.00
COVERED CHARGES	27,815.00	CONTRACTUAL ALLOW	23,121.27
NON-COVERD CHARGES	4,263.75	TOTAL MEDICAID LIAB	4,693.73
		LESS: COB	4,669.73
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.50	0.00
MED/SURG SUPPLY	639.25	562.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,227.00	0.00
CT SCAN	2,687.50	2,105.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	369.75	0.00
IV THERAPY	301.00	0.00
OPERATING ROOM	2,767.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	143.50	0.00
ANESTHESIA	788.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,763.25	0.00
RECOVERY ROOM	1,376.25	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	843.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	712.25	451.50
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	6,163.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	513.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,557.25	1,144.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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 LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	27,815.00	4,263.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,815.00	4,263.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,445.80	ADJUSTMENTS	0.00
COVERED CHARGES	60,422.05	CONTRACTUAL ALLOW	56,730.01
NON-COVERD CHARGES	6,023.75	TOTAL MEDICAID LIAB	3,692.04
		LESS: COB	0.00
		LESS: COPAYMENT	162.01
		REIMBURSEMENT	3,530.03

TOTAL NUMBER OF CLAIMS 66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,634.05	98.75
MED/SURG SUPPLY	157.25	59.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,193.75	0.00
CT SCAN	2,105.00	4,589.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	636.25	0.00
IV THERAPY	5,023.25	258.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	817.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,583.25	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,649.75	795.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	622.25	223.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	60,422.05	6,023.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,422.05	6,023.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	237.00	ADJUSTMENTS	0.00
COVERED CHARGES	237.00	CONTRACTUAL ALLOW	134.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	103.00
		LESS: COB	100.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	237.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	237.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	237.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,450,944.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,032,650.25	CONTRACTUAL ALLOW	892,667.78
NON-COVERD CHARGES	418,294.25	TOTAL MEDICAID LIAB	139,982.47
		LESS: COB	0.00
		LESS: COPAYMENT	420.00
		REIMBURSEMENT	139,562.47

TOTAL NUMBER OF CLAIMS 25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,087.25	1,636.00
MED/SURG SUPPLY	230,276.75	358,321.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,963.75	0.00
CT SCAN	44,822.00	1,192.25
PHYSICAL THERAPY	0.00	181.50
EKG/ECG	1,781.50	0.00
IV THERAPY	20,415.50	0.00
OPERATING ROOM	152,441.00	7,835.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	144.75	0.00
ANESTHESIA	8,080.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	9,047.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	136,206.50	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	373.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	993.50	699.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,274.50	39.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	45,739.75	6,898.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,832.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,225.00	2,322.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	320,945.00	39,167.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,032,650.25	418,294.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,032,650.25	418,294.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,484,150.69	ADJUSTMENTS	620,939.02
COVERED CHARGES	13,675,926.38	CONTRACTUAL ALLOW	9,338,561.68
NON-COVERD CHARGES	808,224.31	TOTAL MEDICAID LIAB	4,337,364.70
		LESS: COB	37,118.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,300,245.85

TOTAL NUMBER OF ADMISSIONS 467

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,377	0	1,218,608.00	67,742.00
ROUTINE NURSERY	198	0	157,238.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,575	0	1,375,846.00	67,742.00
SPECIAL CARE SERVICES				
CCU	23	0	1,737.00	0.00
ICU	735	0	1,276,620.00	0.00
NICU	11	0	20,559.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	219	0.00	199,873.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	769	219	1,298,916.00	199,873.00
TOTAL ACCOMODATIONS	2,344	219	2,674,762.00	267,615.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,874,604.77	12,394.81
MED/SURG SUPPLY	1,147,780.83	12,611.14
LABORATORY-GENERAL	1,640,005.76	6,930.00
RADIOLOGY-DIAGNOSTIC	303,528.00	321.00
CT SCAN	0.00	476,595.00
PHYSICAL THERAPY	172,680.00	637.00
EKG/ECG	74,764.00	0.00
IV THERAPY	13,264.51	0.00
OPERATING ROOM	1,186,162.00	8,893.00
LABOR/DELIVERY ROOM	140,545.00	0.00
RESPIRATORY SERVICES	737,838.00	5,465.00
ANESTHESIA	316,317.00	0.00
GI SERVICES	55,734.00	0.00
EMERGENCY ROOM	573,131.00	4,794.00
RECOVERY ROOM	219,078.00	0.00
LABORATORY PATHOLOGIC	55,841.51	0.00
RADIOLOGY THERAPEUTIC	4,704.00	0.00
OCCUPATIONAL THERAPY	126,263.00	1,785.00
SPEECH PATHOLOGY	156,156.64	66.36
RENAL DIALYSIS	44,442.00	3,292.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	224.00
PSYCHIATRIC SERVICES	341.00	0.00
LITHOTRIPSY	15,421.00	0.00
OTHER IMAGING SERVICE	91,852.00	416.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	79,078.00	486.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	34,086.00	5,699.00
AUDIOLOGY	3,850.00	0.00
CARDIOLOGY	484,129.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	59,721.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,524.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	99,627.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	264,349.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,346.36	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,001,164.38	540,609.31
TOTAL ACCOMODATIONS	2,674,762.00	267,615.00
TOTAL CHARGES	13,675,926.38	808,224.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,544.44	ADJUSTMENTS	0.00
COVERED CHARGES	74,390.44	CONTRACTUAL ALLOW	34,949.62
NON-COVERD CHARGES	154.00	TOTAL MEDICAID LIAB	39,440.82
		LESS: COB	39,440.82
		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	0	0	0.00	0.00
ROUTINE NURSERY	39	0	36,574.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	39	0	36,574.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	39	0	36,574.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,782.02	0.00
MED/SURG SUPPLY	1,089.00	0.00
LABORATORY-GENERAL	12,472.79	0.00
RADIOLOGY-DIAGNOSTIC	642.00	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	158.00	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	2,581.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	786.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	154.00
CARDIOLOGY	2,581.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,724.63	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,816.44	154.00
TOTAL ACCOMODATIONS	36,574.00	0.00
TOTAL CHARGES	74,390.44	154.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,791,557.01	ADJUSTMENTS	184,271.04
COVERED CHARGES	8,643,182.81	CONTRACTUAL ALLOW	6,858,576.93
NON-COVERD CHARGES	1,148,374.20	TOTAL MEDICAID LIAB	1,784,605.88
		LESS: COB	10,119.58
		LESS: COPAYMENT	3,989.51
		REIMBURSEMENT	1,770,496.79
		ALL OTHER	1,575,598.05
		FEE SCHEDULE-LAB	136,127.79
		INJECTABLE DRUGS	58,770.95

TOTAL NUMBER OF CLAIMS 4,080

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,688.68	2,649.10
MED/SURG SUPPLY	286,097.00	98,266.65
LABORATORY-GENERAL	0.00	1,383.91
RADIOLOGY-DIAGNOSTIC	470,991.10	15,911.00
CT SCAN	616,041.00	142,903.00
PHYSICAL THERAPY	23,682.00	4,444.00
EKG/ECG	105,985.00	1,055.00
IV THERAPY	342,547.00	33,554.00
OPERATING ROOM	968,985.83	138,499.17
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	51,972.00	0.00
ANESTHESIA	363,579.00	0.00
GI SERVICES	118,037.00	31,682.00
EMERGENCY ROOM	1,443,936.54	21,881.00
RECOVERY ROOM	480,402.00	0.00
LABORATORY PATHOLOGIC	0.00	257.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,568.00	3,583.00
SPEECH PATHOLOGY	4,329.00	4,134.00
RENAL DIALYSIS	0.00	215.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	80,175.00	3,756.00
PSYCHIATRIC SERVICES	15,004.00	0.00
LITHOTRIPSY	15,421.00	0.00
OTHER IMAGING SERVICE	239,610.00	16,391.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,967.00	7,320.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	143,964.00	30,413.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	247,664.00	191,047.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	180,432.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	111,358.00	2,254.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	79,945.00	222.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	768.00	100.00
OTHER THERAPEUTIC SVC	0.00	9,823.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,276,482.46	165,343.32
MRI SERVICES	287,151.00	15,671.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	470,400.20	205,146.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,643,182.81	1,147,904.19
TOTAL ACCOMODATIONS	0.00	470.01
TOTAL CHARGES	8,643,182.81	1,148,374.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	116,630.64	ADJUSTMENTS	0.00
COVERED CHARGES	88,497.24	CONTRACTUAL ALLOW	44,310.99
NON-COVERD CHARGES	28,133.40	TOTAL MEDICAID LIAB	44,186.25
		LESS: COB	44,144.25
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,080.86	0.00
MED/SURG SUPPLY	250.00	5.00
LABORATORY-GENERAL	0.00	24.00
RADIOLOGY-DIAGNOSTIC	4,377.00	0.00
CT SCAN	0.00	7,008.00
PHYSICAL THERAPY	2,158.00	273.00
EKG/ECG	211.00	0.00
IV THERAPY	3,076.00	0.00
OPERATING ROOM	8,897.00	6,125.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	7,130.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,729.00	154.00
RECOVERY ROOM	9,116.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,746.00	449.00
SPEECH PATHOLOGY	196.00	2,133.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,250.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	520.00	662.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,955.00	626.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	198.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,987.44	1,644.01
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	67.00
INJECTABLE DRUGS	19,619.94	8,812.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	33.50

TOTAL ANCILLARY	88,497.24	28,016.40
TOTAL ACCOMODATIONS	0.00	117.00
TOTAL CHARGES	88,497.24	28,133.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	1111153008333	02/23/11 - 02/23/11	09/19/11	0.00	33.50	0.00	3,331.80	0.00
TOTAL				0.00	33.50	0.00	3,331.80	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	577,123.34	ADJUSTMENTS	990.77
COVERED CHARGES	550,035.05	CONTRACTUAL ALLOW	512,723.12
NON-COVERD CHARGES	27,088.29	TOTAL MEDICAID LIAB	37,311.93
		LESS: COB	0.00
		LESS: COPAYMENT	1,410.11
		REIMBURSEMENT	35,901.82

TOTAL NUMBER OF CLAIMS 667

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,080.32	0.00
MED/SURG SUPPLY	965.00	70.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,064.00	0.00
CT SCAN	10,980.00	8,600.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,587.00	0.00
IV THERAPY	17,452.00	770.00
OPERATING ROOM	0.00	4,250.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,423.00	0.00
ANESTHESIA	1,700.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	298,273.00	792.00
RECOVERY ROOM	2,591.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	115.00	84.00
PSYCHIATRIC SERVICES	3,751.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,713.00	1,182.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	737.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	85,861.28	9,291.22
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,742.45	2,049.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	550,035.05	27,088.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	550,035.05	27,088.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	989.00	ADJUSTMENTS	0.00
COVERED CHARGES	989.00	CONTRACTUAL ALLOW	401.99
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	587.01
		LESS: COB	584.01
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	129.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	860.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	989.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	989.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,006,387.56	ADJUSTMENTS	10,278.66
COVERED CHARGES	702,991.66	CONTRACTUAL ALLOW	593,684.07
NON-COVERD CHARGES	303,395.90	TOTAL MEDICAID LIAB	109,307.59
		LESS: COB	19,323.48
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	89,867.11

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,981.42	0.00
MED/SURG SUPPLY	71,196.00	244,297.52
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,842.00	1,438.00
CT SCAN	4,977.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,165.00	0.00
IV THERAPY	4,794.00	924.00
OPERATING ROOM	377,540.33	43,457.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,099.00	0.00
ANESTHESIA	39,105.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	102,847.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,189.00	160.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	46,251.00	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/OBSERV. RM	6,087.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,610.92	4,396.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,306.99	8,722.11
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	702,991.66	303,395.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	702,991.66	303,395.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,374,892.27	ADJUSTMENTS	29,985.96
COVERED CHARGES	5,319,863.77	CONTRACTUAL ALLOW	3,446,361.72
NON-COVERD CHARGES	55,028.50	TOTAL MEDICAID LIAB	1,873,502.05
		LESS: COB	5,437.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,868,064.87

TOTAL NUMBER OF ADMISSIONS 307

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	733	0	373,305.00	30,830.00
ROUTINE NURSERY	91	0	37,310.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	824	0	410,615.00	30,830.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	608	2	704,580.00	1,500.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	608	2	704,580.00	1,500.00
TOTAL ACCOMODATIONS	1,432	2	1,115,195.00	32,330.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,004,047.63	0.00
MED/SURG SUPPLY	1,134,720.17	0.00
LABORATORY-GENERAL	603,498.31	0.00
RADIOLOGY-DIAGNOSTIC	96,928.50	0.00
CT SCAN	177,109.00	2,294.50
PHYSICAL THERAPY	98,688.25	0.00
EKG/ECG	28,583.00	0.00
IV THERAPY	24,265.00	0.00
OPERATING ROOM	91,513.25	0.00
LABOR/DELIVERY ROOM	63,562.55	0.00
RESPIRATORY SERVICES	406,342.25	0.00
ANESTHESIA	28,825.75	0.00
GI SERVICES	9,982.00	0.00
EMERGENCY ROOM	95,933.00	0.00
RECOVERY ROOM	39,552.68	0.00
LABORATORY PATHOLOGIC	7,128.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,259.75	0.00
RENAL DIALYSIS	18,639.50	1,190.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,093.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,198.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,888.00	1,673.00
AUDIOLOGY	2,547.75	0.00
CARDIOLOGY	30,121.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,018.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	137,085.01	10,758.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	19,750.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	18,884.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,501.92	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	6,782.00

TOTAL ANCILLARY	4,204,668.77	22,698.50
TOTAL ACCOMODATIONS	1,115,195.00	32,330.00
TOTAL CHARGES	5,319,863.77	55,028.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2011194039880	06/19/11 - 06/21/11	07/18/11	0.00	1,455.25	0.00	0.00	0.00
616	2011224046266	07/20/11 - 07/26/11	08/15/11	0.00	1,329.75	0.00	0.00	0.00
616	2011231028397	07/26/11 - 08/03/11	08/22/11	0.00	2,663.00	0.00	0.00	0.00
616	2011364034916	09/30/11 - 10/05/11	01/02/12	0.00	1,334.00	0.00	0.00	0.00
TOTAL				0.00	6,782.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,054.71	ADJUSTMENTS	0.00
COVERED CHARGES	31,854.71	CONTRACTUAL ALLOW	7,177.42
NON-COVERD CHARGES	200.00	TOTAL MEDICAID LIAB	24,677.29
		LESS: COB	24,677.29
		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	5	0	2,545.00	200.00
ROUTINE NURSERY	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	2,545.00	200.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	2,545.00	200.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,375.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,710.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,402.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	156.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	172.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	480.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,699.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,114.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,272.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,166.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	109.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,037.25	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/OBSERV. RM	1,557.75	0.00			

TOTAL ANCILLARY	29,309.71	0.00
TOTAL ACCOMODATIONS	2,545.00	200.00
TOTAL CHARGES	31,854.71	200.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,092,778.27	ADJUSTMENTS	34,116.96
COVERED CHARGES	2,732,410.96	CONTRACTUAL ALLOW	1,731,622.65
NON-COVERD CHARGES	360,367.31	TOTAL MEDICAID LIAB	1,000,788.31
		LESS: COB	2,918.59
		LESS: COPAYMENT	3,498.49
		REIMBURSEMENT	994,371.23
		ALL OTHER	928,788.27
		FEE SCHEDULE-LAB	63,802.30
		INJECTABLE DRUGS	1,780.66

TOTAL NUMBER OF CLAIMS 2,559

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,715.34	19,684.93
MED/SURG SUPPLY	389,639.32	28,537.20
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	158,189.00	6,899.25
CT SCAN	365,297.25	65,141.25
PHYSICAL THERAPY	100,512.00	8,774.25
EKG/ECG	39,208.00	863.75
IV THERAPY	35,305.00	0.00
OPERATING ROOM	85,851.48	61,674.25
LABOR/DELIVERY ROOM	113.18	234.75
RESPIRATORY SERVICES	47,118.50	3,827.25
ANESTHESIA	49,502.50	0.00
GI SERVICES	26,672.00	1,738.50
EMERGENCY ROOM	365,387.87	674.00
RECOVERY ROOM	74,037.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,123.50	2,255.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	24.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	62,849.25	4,032.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,788.00	6,686.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	79,678.50	13,384.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,358.50	336.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,527.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	142,229.37	40,793.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	28,346.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	355,473.98	56,585.50
MRI SERVICES	82,136.75	5,598.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,349.92	28,258.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,362.50

TOTAL ANCILLARY	2,732,410.96	360,367.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,732,410.96	360,367.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2011200022364	12/01/10 - 12/01/10	07/25/11	0.00	1,699.50	0.00	0.00	0.00
616	2211306016056	08/18/11 - 08/18/11	11/07/11	0.00	2,663.00	0.00	0.00	0.00
TOTAL				0.00	4,362.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	62,562.63	ADJUSTMENTS	0.00
COVERED CHARGES	50,605.33	CONTRACTUAL ALLOW	5,766.08
NON-COVERD CHARGES	11,957.30	TOTAL MEDICAID LIAB	44,839.25
		LESS: COB	44,810.92
		LESS: COPAYMENT	28.33
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,067.51	1,054.45
MED/SURG SUPPLY	7,810.29	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,857.50	345.50
CT SCAN	0.00	7,743.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	321.25	0.00
IV THERAPY	585.00	0.00
OPERATING ROOM	4,693.50	0.00
LABOR/DELIVERY ROOM	2,264.18	0.00
RESPIRATORY SERVICES	66.50	0.00
ANESTHESIA	2,258.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,565.50	785.75
RECOVERY ROOM	3,130.50	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 SERVICE	3,497.50	937.50
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/OBSERV. RM	1,796.05	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	579.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,076.75	1,046.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	44.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	50,605.33	11,957.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	50,605.33	11,957.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	236,160.16	ADJUSTMENTS	290.64
COVERED CHARGES	221,160.73	CONTRACTUAL ALLOW	195,540.21
NON-COVERD CHARGES	14,999.43	TOTAL MEDICAID LIAB	25,620.52
		LESS: COB	0.00
		LESS: COPAYMENT	795.00
		REIMBURSEMENT	24,825.52

TOTAL NUMBER OF CLAIMS 458

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,592.70	1,963.94
MED/SURG SUPPLY	9,646.79	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,695.00	0.00
CT SCAN	22,147.25	6,953.75
PHYSICAL THERAPY	13,160.25	134.50
EKG/ECG	2,591.25	0.00
IV THERAPY	1,840.00	0.00
OPERATING ROOM	1,053.67	526.83
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,443.75	54.25
ANESTHESIA	492.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	102,333.00	406.50
RECOVERY ROOM	1,083.75	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 SERVICE	2,935.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,894.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,157.92	4,613.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	93.80	345.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	221,160.73	14,999.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	221,160.73	14,999.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,882.95	ADJUSTMENTS	0.00
COVERED CHARGES	4,786.74	CONTRACTUAL ALLOW	1,646.36
NON-COVERD CHARGES	1,096.21	TOTAL MEDICAID LIAB	3,140.38
		LESS: COB	3,134.38
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.24	158.71
MED/SURG SUPPLY	37.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	85.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	66.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,704.25	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 SERVICE	493.25	937.50
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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,017.25	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,786.74	1,096.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,786.74	1,096.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	268,168.61	ADJUSTMENTS	9,950.36
COVERED CHARGES	260,203.71	CONTRACTUAL ALLOW	171,635.46
NON-COVERD CHARGES	7,964.90	TOTAL MEDICAID LIAB	88,568.25
		LESS: COB	0.00
		LESS: COPAYMENT	86.32
		REIMBURSEMENT	88,481.93

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,841.34	423.19	OTHER LAB	1,134.50	0.00
MED/SURG SUPPLY	97,017.71	2,147.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,398.50	1,625.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,989.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,483.85	345.50
EKG/ECG	172.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,001.00	1,332.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,355.00	588.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,794.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,126.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,706.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	969.00	702.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	165.50	799.50			
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/OBSERV. RM	74,888.06	0.00			

TOTAL ANCILLARY	260,203.71	7,964.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	260,203.71	7,964.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	126,964.47	ADJUSTMENTS	0.00
COVERED CHARGES	117,724.47	CONTRACTUAL ALLOW	7,412.57
NON-COVERD CHARGES	9,240.00	TOTAL MEDICAID LIAB	110,311.90
		LESS: COB	2,559.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	107,752.28

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	82	0	31,760.00	9,240.00
ROUTINE NURSERY	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	82	0	31,760.00	9,240.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	82	0	31,760.00	9,240.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,053.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,651.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,879.27	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,681.83	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,507.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	970.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,089.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	379.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,027.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,974.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	700.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	85,964.47	0.00
TOTAL ACCOMODATIONS	31,760.00	9,240.00
TOTAL CHARGES	117,724.47	9,240.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	339,780.86	ADJUSTMENTS	7,495.91
COVERED CHARGES	299,037.47	CONTRACTUAL ALLOW	154,824.45
NON-COVERD CHARGES	40,743.39	TOTAL MEDICAID LIAB	144,213.02
		LESS: COB	0.00
		LESS: COPAYMENT	600.00
		REIMBURSEMENT	143,613.02
		ALL OTHER	129,773.53
		FEE SCHEDULE-LAB	13,839.49
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 416

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,595.69	0.00
MED/SURG SUPPLY	19,813.83	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,037.10	0.00
CT SCAN	17,174.00	11,711.50
PHYSICAL THERAPY	7,697.00	6,309.00
EKG/ECG	1,782.00	99.00
IV THERAPY	9,487.50	24.78
OPERATING ROOM	3,378.48	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,594.50	0.00
ANESTHESIA	2,656.50	0.00
GI SERVICES	726.00	0.00
EMERGENCY ROOM	36,201.80	0.00
RECOVERY ROOM	9,831.36	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,705.01	0.00
BLOOD	82.50	0.00
BLOOD STORAGE & PRO.	5,230.00	1,980.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	36,077.50	770.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,820.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,146.70	19,799.11
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	50.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	299,037.47	40,743.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	299,037.47	40,743.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107.25	ADJUSTMENTS	0.00
COVERED CHARGES	107.25	CONTRACTUAL ALLOW	55.73
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	51.52
		LESS: COB	51.52
		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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	107.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	107.25	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,783.37	ADJUSTMENTS	214.76
COVERED CHARGES	36,319.23	CONTRACTUAL ALLOW	32,289.07
NON-COVERD CHARGES	3,464.14	TOTAL MEDICAID LIAB	4,030.16
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	3,877.16

TOTAL NUMBER OF CLAIMS 73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,704.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,032.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,398.69	183.88	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,145.00	1,072.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,060.62	2,207.76
EKG/ECG	99.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,518.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	418.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,541.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,400.00	0.00			

TOTAL ANCILLARY	36,319.23	3,464.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,319.23	3,464.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,472.98	ADJUSTMENTS	0.00
COVERED CHARGES	13,472.98	CONTRACTUAL ALLOW	8,617.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,855.93
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,852.93

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,417.98	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	55.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,472.98	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,472.98	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL
580 ALSTON ST
RICHLAND,GA 31825-6012

PROVIDER NUMBER
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	251,916.92	ADJUSTMENTS	11,459.57
COVERED CHARGES	233,187.40	CONTRACTUAL ALLOW	168,881.80
NON-COVERD CHARGES	18,729.52	TOTAL MEDICAID LIAB	64,305.60
		LESS: COB	1,222.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	63,082.98

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	34	8	24,499.00	18,729.52
ROUTINE NURSERY	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	34	8	24,499.00	18,729.52
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	34	8	24,499.00	18,729.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,455.42	0.00	OTHER LAB	1,182.75	0.00
MED/SURG SUPPLY	44,764.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,095.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,704.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,542.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	966.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,222.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,511.07	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,549.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94.87	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,597.59	0.00			

TOTAL ANCILLARY	208,688.40	0.00
TOTAL ACCOMODATIONS	24,499.00	18,729.52
TOTAL CHARGES	233,187.40	18,729.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,881,895.29	ADJUSTMENTS	25,150.18
COVERED CHARGES	1,684,207.97	CONTRACTUAL ALLOW	1,405,752.12
NON-COVERD CHARGES	197,687.32	TOTAL MEDICAID LIAB	278,455.85
		LESS: COB	1,150.10
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	276,936.75
		ALL OTHER	256,994.79
		FEE SCHEDULE-LAB	18,318.76
		INJECTABLE DRUGS	1,623.20

TOTAL NUMBER OF CLAIMS 1,026

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,272.15	39.43
MED/SURG SUPPLY	55,764.95	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	174,182.30	2,392.77
CT SCAN	132,256.63	91,515.55
PHYSICAL THERAPY	1,429.26	3,470.44
EKG/ECG	23,852.91	0.00
IV THERAPY	7,392.68	562.72
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,402.40	4,393.68
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	810,586.92	1,741.74
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	0.00	389.82
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	255.56	1,627.01
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,925.52	1,189.56
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,510.19	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,864.31	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	303,284.76	75,724.32
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89,227.43	14,640.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,684,207.97	197,687.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,684,207.97	197,687.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,886.96	ADJUSTMENTS	0.00
COVERED CHARGES	13,590.62	CONTRACTUAL ALLOW	9,199.69
NON-COVERD CHARGES	296.34	TOTAL MEDICAID LIAB	4,390.93
		LESS: COB	4,390.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.47	0.00
MED/SURG SUPPLY	894.23	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,502.22	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	95.30	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	6,168.82	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,690.45	110.55
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,197.13	185.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,590.62	296.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,590.62	296.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	250,171.55	ADJUSTMENTS	140.99
COVERED CHARGES	232,488.87	CONTRACTUAL ALLOW	220,989.20
NON-COVERD CHARGES	17,682.68	TOTAL MEDICAID LIAB	11,499.67
		LESS: COB	0.00
		LESS: COPAYMENT	432.02
		REIMBURSEMENT	11,067.65

TOTAL NUMBER OF CLAIMS 230

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,388.24	6.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,863.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,058.43	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,776.97	9,178.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,003.29	5,232.11
EKG/ECG	801.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	462.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	536.83	361.62	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	159,094.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,538.27	1,558.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,964.48	1,345.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	232,488.87	17,682.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	232,488.87	17,682.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/11	THROUGH	12/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,545,737.33	ADJUSTMENTS	713,392.90
COVERED CHARGES	13,286,448.00	CONTRACTUAL ALLOW	8,884,493.37
NON-COVERD CHARGES	259,289.33	TOTAL MEDICAID LIAB	4,401,954.63
		LESS: COB	8,339.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,393,615.23

TOTAL NUMBER OF ADMISSIONS 564

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,213	79	1,015,281.00	138,475.00
ROUTINE NURSERY	215	0	112,360.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,428	79	1,127,641.00	138,475.00
SPECIAL CARE SERVICES				
CCU	414	0	543,798.00	0.00
ICU	184	0	390,080.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	598	0	933,878.00	0.00
TOTAL ACCOMODATIONS	2,026	79	2,061,519.00	138,475.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,491,678.24	482.13
MED/SURG SUPPLY	1,763,301.39	1,329.00
LABORATORY-GENERAL	1,704,770.00	450.00
RADIOLOGY-DIAGNOSTIC	254,523.00	0.00
CT SCAN	475,000.00	2,180.00
PHYSICAL THERAPY	79,835.00	0.00
EKG/ECG	85,875.00	0.00
IV THERAPY	21,139.00	0.00
OPERATING ROOM	1,195,319.00	1,700.00
LABOR/DELIVERY ROOM	304,984.00	0.00
RESPIRATORY SERVICES	637,183.00	751.00
ANESTHESIA	0.00	0.00
GI SERVICES	36,630.00	0.00
EMERGENCY ROOM	349,736.00	1,340.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	32,964.00	0.00
RADIOLOGY THERAPEUTIC	111,672.00	0.00
OCCUPATIONAL THERAPY	2,120.00	0.00
SPEECH PATHOLOGY	9,948.00	0.00
RENAL DIALYSIS	0.00	68,550.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,510.00	220.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	45,698.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	189,897.00	5,670.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	180,338.00	930.00
AUDIOLOGY	6,794.00	0.00
CARDIOLOGY	856,534.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,150.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	42,883.00	8,036.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	103,145.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,129.00	42.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	126,320.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	26,294.20
INJECTABLE DRUGS	1,096,853.21	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,840.00

TOTAL ANCILLARY	11,224,929.00	120,814.33
TOTAL ACCOMODATIONS	2,061,519.00	138,475.00
TOTAL CHARGES	13,286,448.00	259,289.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	9112086010012	04/05/11 - 04/07/11	04/16/12	0.00	2,840.00	0.00	1,761.13	0.00
TOTAL				0.00	2,840.00	0.00	1,761.13	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,353.35	ADJUSTMENTS	0.00
COVERED CHARGES	10,297.35	CONTRACTUAL ALLOW	10,297.35
NON-COVERD CHARGES	56.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		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	1	0	837.00	56.00
ROUTINE NURSERY	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	837.00	56.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	837.00	56.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,608.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	812.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	482.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,197.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	46.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	166.00	0.00			

TOTAL ANCILLARY	9,460.35	0.00
TOTAL ACCOMODATIONS	837.00	56.00
TOTAL CHARGES	10,297.35	56.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,139,089.16	ADJUSTMENTS	997,912.95
COVERED CHARGES	12,686,902.71	CONTRACTUAL ALLOW	9,354,312.75
NON-COVERD CHARGES	1,452,186.45	TOTAL MEDICAID LIAB	3,332,589.96
		LESS: COB	1,754.42
		LESS: COPAYMENT	10,887.00
		REIMBURSEMENT	3,319,948.54
		ALL OTHER	2,969,820.78
		FEE SCHEDULE-LAB	195,695.87
		INJECTABLE DRUGS	154,431.89

TOTAL NUMBER OF CLAIMS 6,530

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	503,096.65	5,541.54
MED/SURG SUPPLY	541,667.46	2,040.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	643,024.00	23,834.00
CT SCAN	1,423,430.00	168,842.00
PHYSICAL THERAPY	0.00	4,170.00
EKG/ECG	147,486.00	3,800.00
IV THERAPY	287,517.08	11,280.86
OPERATING ROOM	969,586.66	158,982.76
LABOR/DELIVERY ROOM	13,587.00	0.00
RESPIRATORY SERVICES	83,695.00	14,709.00
ANESTHESIA	0.00	0.00
GI SERVICES	96,570.00	17,316.00
EMERGENCY ROOM	1,692,962.38	31,555.39
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	474,428.00	31,995.00
OCCUPATIONAL THERAPY	0.00	212.00
SPEECH PATHOLOGY	0.00	2,114.00
RENAL DIALYSIS	0.00	3,404.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	70,428.20	21,785.00
PSYCHIATRIC SERVICES	914,155.00	6,655.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	479,453.00	28,580.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,771.00	5,968.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	385,909.00	82,931.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	441,753.00	185,730.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166,779.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	341,081.15	9,658.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	155,588.09	2,529.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	446.00	380.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,836,915.40	345,069.40
MRI SERVICES	545,980.00	31,430.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,807.20
INJECTABLE DRUGS	452,593.64	249,690.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	176.00

TOTAL ANCILLARY	12,686,902.71	1,452,186.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,686,902.71	1,452,186.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3006	5911131001437	12/31/10 - 12/31/10	05/16/11	0.00	176.00	0.00	0.00	0.00
TOTAL				0.00	176.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,744.05	ADJUSTMENTS	0.00
COVERED CHARGES	39,381.00	CONTRACTUAL ALLOW	30,084.51
NON-COVERD CHARGES	9,363.05	TOTAL MEDICAID LIAB	9,296.49
		LESS: COB	9,263.49
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,547.42	0.00	OTHER LAB	239.00	0.00
MED/SURG SUPPLY	1,234.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	450.00
RADIOLOGY-DIAGNOSTIC	945.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,300.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,872.00	2,691.00
EKG/ECG	600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	435.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,697.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,711.75	225.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,564.83	4,027.80
RADIOLOGY THERAPEUTIC	634.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	251.00	1,329.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	350.00	640.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	39,381.00	9,363.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,381.00	9,363.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	592,571.30	ADJUSTMENTS	6,413.00
COVERED CHARGES	562,043.73	CONTRACTUAL ALLOW	519,867.04
NON-COVERD CHARGES	30,527.57	TOTAL MEDICAID LIAB	42,176.69
		LESS: COB	10.68
		LESS: COPAYMENT	1,395.17
		REIMBURSEMENT	40,770.84

TOTAL NUMBER OF CLAIMS 756

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,344.31	0.00	OTHER LAB	7,160.00	0.00
MED/SURG SUPPLY	19,841.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,340.00	200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,200.00	1,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,397.00	12,770.00
EKG/ECG	7,600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,635.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,969.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,132.00	121.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	284,086.02	3,273.23	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,015.32	11,343.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	46.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,560.00	1,220.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,717.00	0.00			

TOTAL ANCILLARY	562,043.73	30,527.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	562,043.73	30,527.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,501.84	ADJUSTMENTS	0.00
COVERED CHARGES	4,483.84	CONTRACTUAL ALLOW	3,416.28
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	1,067.56
		LESS: COB	1,055.55
		LESS: COPAYMENT	12.01
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	490.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	970.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,266.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,483.84	18.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,483.84	18.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,168,288.62	ADJUSTMENTS	304,668.76
COVERED CHARGES	3,732,953.36	CONTRACTUAL ALLOW	2,992,281.83
NON-COVERD CHARGES	435,335.26	TOTAL MEDICAID LIAB	740,671.53
		LESS: COB	0.00
		LESS: COPAYMENT	1,842.00
		REIMBURSEMENT	738,829.53

TOTAL NUMBER OF CLAIMS 144

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	169,163.90	1,507.00
MED/SURG SUPPLY	601,508.09	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,441.00	49,809.00
CT SCAN	13,800.00	3,600.00
PHYSICAL THERAPY	0.00	2,695.00
EKG/ECG	17,600.00	1,000.00
IV THERAPY	95,478.00	1,012.00
OPERATING ROOM	467,452.49	47,149.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	23,991.00	726.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,332.00	0.00
EMERGENCY ROOM	16,819.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	670,862.00	438.00
OCCUPATIONAL THERAPY	0.00	212.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,350.00	1,525.00
PSYCHIATRIC SERVICES	108,900.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	500.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,751.00	638.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,828.00	5,580.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	583,699.00	74,863.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,523.00	392.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,630.58	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	210.00	190.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	128,626.10	40,593.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	589,488.20	203,405.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,732,953.36	435,335.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,732,953.36	435,335.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,983.99	ADJUSTMENTS	0.00
COVERED CHARGES	54,785.55	CONTRACTUAL ALLOW	54,755.55
NON-COVERD CHARGES	10,198.44	TOTAL MEDICAID LIAB	30.00
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,731.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,017.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,750.85	10,198.44
RADIOLOGY THERAPEUTIC	826.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	460.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	54,785.55	10,198.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	54,785.55	10,198.44

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,695,197.50	ADJUSTMENTS	6,033.42
COVERED CHARGES	2,676,469.55	CONTRACTUAL ALLOW	2,377,720.59
NON-COVERD CHARGES	18,727.95	TOTAL MEDICAID LIAB	298,748.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	298,748.96

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	86	0	46,005.00	18,409.00
ROUTINE NURSERY	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	86	0	46,005.00	18,409.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	86	0	46,005.00	18,409.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,821.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	492,812.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	68,959.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,922.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,629.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,344.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,276.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,886,037.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,111.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,192.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,884.35	318.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,097.15	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,414.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,409.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50.90	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,630,464.55	318.95
TOTAL ACCOMODATIONS	46,005.00	18,409.00
TOTAL CHARGES	2,676,469.55	18,727.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,011,349.31	ADJUSTMENTS	67,894.99
COVERED CHARGES	3,128,446.85	CONTRACTUAL ALLOW	2,468,913.44
NON-COVERD CHARGES	1,882,902.46	TOTAL MEDICAID LIAB	659,533.41
		LESS: COB	3,181.22
		LESS: COPAYMENT	3,603.00
		REIMBURSEMENT	652,749.19
		ALL OTHER	600,202.39
		FEE SCHEDULE-LAB	51,856.76
		INJECTABLE DRUGS	690.04

TOTAL NUMBER OF CLAIMS 2,193

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,150.06	62,498.61
MED/SURG SUPPLY	138,409.11	26,328.65
LABORATORY-GENERAL	0.00	1,743.40
RADIOLOGY-DIAGNOSTIC	265,803.06	16,736.87
CT SCAN	151,114.65	120,714.50
PHYSICAL THERAPY	9,149.50	12,039.25
EKG/ECG	27,505.55	172.45
IV THERAPY	0.00	0.00
OPERATING ROOM	1,099,288.99	1,400,366.26
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,413.55	3,444.40
ANESTHESIA	1,500.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	225,313.35	3,467.30
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	961.90	709.40
SPEECH PATHOLOGY	1,046.75	1,432.62
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	36,846.00	707.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,118.40	2,356.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,309.90	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/OBSERV. RM	22,312.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	187,585.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	614,172.58	186,364.80
MRI SERVICES	190,718.50	28,527.30
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	41,726.75	14,453.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	91.30

TOTAL ANCILLARY	3,128,446.85	1,882,153.46
TOTAL ACCOMODATIONS	0.00	749.00
TOTAL CHARGES	3,128,446.85	1,882,902.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
236	5911304000366	10/03/11 - 10/03/11	11/07/11	0.00	2.00	0.00	0.00	0.00
236	5911304000366	10/03/11 - 10/03/11	11/07/11	0.00	30.55	0.00	0.00	0.00
236	5911304000366	10/03/11 - 10/03/11	11/07/11	0.00	58.75	0.00	0.00	0.00
TOTAL				0.00	91.30	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,687.80	ADJUSTMENTS	0.00
COVERED CHARGES	53,833.75	CONTRACTUAL ALLOW	50,692.70
NON-COVERD CHARGES	3,854.05	TOTAL MEDICAID LIAB	3,141.05
		LESS: COB	3,120.41
		LESS: COPAYMENT	20.64
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	875.55	402.50
MED/SURG SUPPLY	168.05	138.55
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,023.55	0.00
CT SCAN	0.00	1,889.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	172.45	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	46,995.15	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	1,041.70	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	50.90	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,308.45	1,280.55
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	197.95	143.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	53,833.75	3,854.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,833.75	3,854.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,716.70	ADJUSTMENTS	438.00
COVERED CHARGES	72,520.95	CONTRACTUAL ALLOW	66,770.95
NON-COVERD CHARGES	10,195.75	TOTAL MEDICAID LIAB	5,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	213.02
		REIMBURSEMENT	5,536.98

TOTAL NUMBER OF CLAIMS 115

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,416.40	1,964.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,090.55	679.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,479.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,512.25	3,390.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,388.05	2,490.30
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	503.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,947.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,037.00	964.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,086.75	707.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50.90	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/OBSERV. RM	837.30	0.00			

TOTAL ANCILLARY	72,520.95	10,195.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,520.95	10,195.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,899.45	ADJUSTMENTS	0.00
COVERED CHARGES	3,586.75	CONTRACTUAL ALLOW	3,513.57
NON-COVERD CHARGES	312.70	TOTAL MEDICAID LIAB	73.18
		LESS: COB	70.18
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,695.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,055.30	312.70
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	540.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,586.75	312.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,586.75	312.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,009,743.94	ADJUSTMENTS	36,038.49
COVERED CHARGES	2,626,253.56	CONTRACTUAL ALLOW	2,281,518.52
NON-COVERD CHARGES	383,490.38	TOTAL MEDICAID LIAB	344,735.04
		LESS: COB	3,714.63
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	340,828.41

TOTAL NUMBER OF CLAIMS 78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,712.70	20,819.97
MED/SURG SUPPLY	331,097.07	15,681.55
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,437.95	7,890.85
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,304.95
EKG/ECG	3,793.90	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,234,282.34	333,904.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	873.20	0.00
ANESTHESIA	1,000.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	915.20	392.70
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,963.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,771.90	190.30
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,806.00	3,305.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,626,253.56	383,490.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,626,253.56	383,490.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	84,094.27	ADJUSTMENTS	0.00
COVERED CHARGES	83,426.77	CONTRACTUAL ALLOW	47,625.20
NON-COVERD CHARGES	667.50	TOTAL MEDICAID LIAB	35,801.57
		LESS: COB	35,795.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL, THE
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,675.37	101.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,884.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	388.90	FEE SCHEDULE LAB	359.45	0.00
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,840.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,021.20	176.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,126.00	0.00			

TOTAL ANCILLARY	83,426.77	667.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,426.77	667.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,416,002.91	ADJUSTMENTS	990,933.66
COVERED CHARGES	25,938,678.87	CONTRACTUAL ALLOW	18,033,913.51
NON-COVERD CHARGES	477,324.04	TOTAL MEDICAID LIAB	7,904,765.36
		LESS: COB	60,229.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,844,535.59

TOTAL NUMBER OF ADMISSIONS 1,003

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,288	0	1,863,405.00	281,225.00
ROUTINE NURSERY	290	0	145,785.00	16,565.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,578	0	2,009,190.00	297,790.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	912	0	1,265,586.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	912	0	1,265,586.00	0.00
TOTAL ACCOMODATIONS	4,490	0	3,274,776.00	297,790.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,240,977.80	82.89
MED/SURG SUPPLY	3,536,244.10	32,956.25
LABORATORY-GENERAL	3,925,897.67	7,211.75
RADIOLOGY-DIAGNOSTIC	595,385.75	0.00
CT SCAN	1,002,323.50	2,616.00
PHYSICAL THERAPY	139,013.25	2,195.00
EKG/ECG	402,413.25	0.00
IV THERAPY	103,825.00	1,523.25
OPERATING ROOM	995,230.50	2,468.00
LABOR/DELIVERY ROOM	134,603.00	0.00
RESPIRATORY SERVICES	1,198,476.00	4,435.00
ANESTHESIA	245,073.50	1,713.75
GI SERVICES	106,298.75	0.00
EMERGENCY ROOM	546,534.00	1,680.25
RECOVERY ROOM	175,736.25	0.00
LABORATORY PATHOLOGIC	121,985.50	0.00
RADIOLOGY THERAPEUTIC	86,515.50	1,825.00
OCCUPATIONAL THERAPY	21,272.50	0.00
SPEECH PATHOLOGY	14,895.50	0.00
RENAL DIALYSIS	6,715.50	3,052.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,232.25	3,560.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	101,761.50	17,548.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	721,324.00	51,377.50
ONCOLOGY	94.50	0.00
NUCLEAR MEDICINE	158,405.50	11,237.25
AUDIOLOGY	24,360.00	0.00
CARDIOLOGY	688,564.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,624.50	0.00
ORGAN ACQUISITION	0.00	2,547.00
TREATMENT/OBSERV. RM	254,303.45	14,185.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	155,721.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	194.00	0.00
OTHER THERAPEUTIC SVC	0.00	7,997.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	194,249.25	0.00
PROFESSIONAL FEES	0.00	9,315.75
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	972.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,718,679.60	4.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,663,902.87	179,534.04
TOTAL ACCOMODATIONS	3,274,776.00	297,790.00
TOTAL CHARGES	25,938,678.87	477,324.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,256.38	ADJUSTMENTS	0.00
COVERED CHARGES	54,747.38	CONTRACTUAL ALLOW	6,446.04
NON-COVERD CHARGES	2,509.00	TOTAL MEDICAID LIAB	48,301.34
		LESS: COB	48,301.34
		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	4	0	2,220.00	490.00
ROUTINE NURSERY	13	0	6,500.00	1,120.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	0	8,720.00	1,610.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	5,750.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	5,750.00	0.00
TOTAL ACCOMODATIONS	22	0	14,470.00	1,610.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,296.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,954.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,142.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,963.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,479.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	728.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	264.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	156.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,215.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	915.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	633.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,284.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	214.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	273.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	609.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,150.00	899.00			

TOTAL ANCILLARY	40,277.38	899.00
TOTAL ACCOMODATIONS	14,470.00	1,610.00
TOTAL CHARGES	54,747.38	2,509.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,404,073.73	ADJUSTMENTS	82,282.97
COVERED CHARGES	14,308,275.62	CONTRACTUAL ALLOW	11,364,937.29
NON-COVERD CHARGES	2,095,798.11	TOTAL MEDICAID LIAB	2,943,338.33
		LESS: COB	2,045.45
		LESS: COPAYMENT	10,581.44
		REIMBURSEMENT	2,930,711.44
		ALL OTHER	2,225,482.25
		FEE SCHEDULE-LAB	298,481.61
		INJECTABLE DRUGS	406,747.58

TOTAL NUMBER OF CLAIMS 8,136

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	863,784.37	5,573.51
MED/SURG SUPPLY	814,335.95	20,763.50
LABORATORY-GENERAL	0.00	219.75
RADIOLOGY-DIAGNOSTIC	642,632.75	18,439.25
CT SCAN	1,238,502.75	242,106.50
PHYSICAL THERAPY	3,854.00	13,349.75
EKG/ECG	195,349.50	17,252.75
IV THERAPY	313,043.75	19,754.75
OPERATING ROOM	412,848.25	243,413.50
LABOR/DELIVERY ROOM	26,697.00	280.25
RESPIRATORY SERVICES	78,546.50	178.75
ANESTHESIA	119,844.00	0.00
GI SERVICES	69,524.00	28,345.25
EMERGENCY ROOM	1,617,582.75	7,077.00
RECOVERY ROOM	190,433.75	0.00
LABORATORY PATHOLOGIC	0.00	217.75
RADIOLOGY THERAPEUTIC	426,968.50	1,036.50
OCCUPATIONAL THERAPY	0.00	1,358.75
SPEECH PATHOLOGY	0.00	1,591.50
RENAL DIALYSIS	0.00	609.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	67,642.50	5,909.78
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	472,409.25	44,427.75
BLOOD	68.25	0.00
BLOOD STORAGE & PRO.	134,570.85	57,593.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	284,556.00	7,868.75
AUDIOLOGY	927.00	2,233.00
CARDIOLOGY	361,484.25	42,500.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	25,193.50	717.75
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	189,405.55	1,737.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	323,796.75	1,158.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,499.00	704.50
OTHER THERAPEUTIC SVC	0.00	50,099.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,026,816.31	720,052.47
MRI SERVICES	362,684.25	18,828.00
PROFESSIONAL FEES	0.00	2,420.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	9,848.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,031,426.34	517,977.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,308,275.62	2,095,798.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,308,275.62	2,095,798.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	219,384.30	ADJUSTMENTS	0.00
COVERED CHARGES	143,158.30	CONTRACTUAL ALLOW	123,777.46
NON-COVERD CHARGES	76,226.00	TOTAL MEDICAID LIAB	19,380.84
		LESS: COB	19,285.79
		LESS: COPAYMENT	95.05
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,060.90	0.00
MED/SURG SUPPLY	5,078.00	243.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,156.75	352.50
CT SCAN	1,479.00	3,783.00
PHYSICAL THERAPY	0.00	1,297.50
EKG/ECG	1,185.25	0.00
IV THERAPY	3,186.00	0.00
OPERATING ROOM	2,510.50	0.00
LABOR/DELIVERY ROOM	280.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	371.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,418.25	0.00
RECOVERY ROOM	1,427.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,097.50	0.00
OCCUPATIONAL THERAPY	0.00	4,531.75
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	296.25	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,587.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	410.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,297.00	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/OBSERV. RM	1,060.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	95.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21,063.50	4,729.50
MRI SERVICES	5,094.00	0.00
PROFESSIONAL FEES	0.00	900.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,098.40	60,292.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	143,158.30	76,226.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	143,158.30	76,226.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	707,667.18	ADJUSTMENTS	261.70
COVERED CHARGES	653,961.71	CONTRACTUAL ALLOW	610,760.64
NON-COVERD CHARGES	53,705.47	TOTAL MEDICAID LIAB	43,201.07
		LESS: COB	0.00
		LESS: COPAYMENT	1,581.02
		REIMBURSEMENT	41,620.05

TOTAL NUMBER OF CLAIMS 787

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,721.97	497.35
MED/SURG SUPPLY	8,049.50	1,748.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,134.00	96.25
CT SCAN	38,930.50	4,289.25
PHYSICAL THERAPY	0.00	2,649.75
EKG/ECG	9,990.00	271.75
IV THERAPY	7,996.50	190.50
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	280.25	0.00
RESPIRATORY SERVICES	2,116.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	293,452.75	571.50
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	98.50	119.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,233.50	1,170.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,980.25	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/OBSERV. RM	2,433.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	191,528.50	41,144.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	306.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,016.14	650.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	653,961.71	53,705.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	653,961.71	53,705.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,628.24	ADJUSTMENTS	0.00
COVERED CHARGES	34,767.24	CONTRACTUAL ALLOW	31,795.80
NON-COVERD CHARGES	861.00	TOTAL MEDICAID LIAB	2,971.44
		LESS: COB	2,906.50
		LESS: COPAYMENT	64.94
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	533.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.50	22.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	657.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,542.25	391.25
EKG/ECG	370.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	306.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,722.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	345.57	0.00
RADIOLOGY THERAPEUTIC	24,513.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	34,767.24	719.25
TOTAL ACCOMODATIONS	0.00	141.75
TOTAL CHARGES	34,767.24	861.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,482,270.18	ADJUSTMENTS	10,370.66
COVERED CHARGES	2,366,308.21	CONTRACTUAL ALLOW	1,979,246.01
NON-COVERD CHARGES	115,961.97	TOTAL MEDICAID LIAB	387,062.20
		LESS: COB	0.00
		LESS: COPAYMENT	678.00
		REIMBURSEMENT	386,384.20

TOTAL NUMBER OF CLAIMS 76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,373.92	1,850.57
MED/SURG SUPPLY	594,998.80	402.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,785.75	1,033.00
CT SCAN	15,731.00	0.00
PHYSICAL THERAPY	0.00	622.25
EKG/ECG	3,251.25	0.00
IV THERAPY	17,229.89	0.00
OPERATING ROOM	112,578.00	39,366.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,590.75	0.00
ANESTHESIA	21,904.00	0.00
GI SERVICES	0.00	2,711.50
EMERGENCY ROOM	4,534.00	0.00
RECOVERY ROOM	25,153.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	270,865.00	777.00
OCCUPATIONAL THERAPY	0.00	154.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,680.00	996.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,758.25	475.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,325.75	2,076.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,837.25	803.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,353.75	6,042.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,170.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,849.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,778.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	40,052.50	11,414.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	792.75
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,112,284.20	39,666.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,366,308.21	115,961.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,366,308.21	115,961.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
PO BOX 807
TIFTON,GA 31793-0807

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,767.00	ADJUSTMENTS	0.00
COVERED CHARGES	58,329.00	CONTRACTUAL ALLOW	23,173.80
NON-COVERD CHARGES	2,438.00	TOTAL MEDICAID LIAB	35,155.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,155.20

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17	0	9,600.00	600.00
ROUTINE NURSERY	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	17	0	9,600.00	600.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	17	0	9,600.00	600.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,681.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,591.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,081.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,085.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,650.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	308.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	300.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,729.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,964.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,830.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	900.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	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/OBSERV. RM	1,890.00	1,838.00			

TOTAL ANCILLARY	48,729.00	1,838.00
TOTAL ACCOMODATIONS	9,600.00	600.00
TOTAL CHARGES	58,329.00	2,438.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	288,608.62	ADJUSTMENTS	633.57
COVERED CHARGES	253,328.62	CONTRACTUAL ALLOW	168,764.94
NON-COVERD CHARGES	35,280.00	TOTAL MEDICAID LIAB	84,563.68
		LESS: COB	0.00
		LESS: COPAYMENT	558.00
		REIMBURSEMENT	84,005.68
		ALL OTHER	71,861.69
		FEE SCHEDULE-LAB	11,393.47
		INJECTABLE DRUGS	750.52

TOTAL NUMBER OF CLAIMS 419

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,726.00	3,335.00
MED/SURG SUPPLY	6,791.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,015.00	525.00
CT SCAN	30,000.00	13,300.00
PHYSICAL THERAPY	780.00	58.00
EKG/ECG	3,267.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,999.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,689.00	1,024.00
EMERGENCY ROOM	48,519.00	120.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	624.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,485.00	450.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,450.00	175.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,216.00	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/OBSERV. RM	1,740.62	905.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,006.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	150.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	57,299.00	13,195.00
MRI SERVICES	14,875.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,847.00	1,993.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	50.00

TOTAL ANCILLARY	253,328.62	35,280.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	253,328.62	35,280.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2011062059510	02/16/11 - 02/16/11	03/07/11	0.00	50.00	0.00	0.00	0.00
TOTAL				0.00	50.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,116.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,670.00	CONTRACTUAL ALLOW	638.04
NON-COVERD CHARGES	1,446.00	TOTAL MEDICAID LIAB	2,031.96
		LESS: COB	2,028.96
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43.00	133.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	179.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	560.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	502.00	128.00
EKG/ECG	77.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,309.00	45.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	40.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,670.00	1,446.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,670.00	1,446.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,072.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,128.00	CONTRACTUAL ALLOW	18,283.00
NON-COVERD CHARGES	944.00	TOTAL MEDICAID LIAB	2,845.00
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	2,737.00

TOTAL NUMBER OF CLAIMS 58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	453.00	669.00
MED/SURG SUPPLY	344.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,745.00	0.00
CT SCAN	2,450.00	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	12,772.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,926.00	111.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	438.00	164.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,128.00	944.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,128.00	944.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	983,584.50	ADJUSTMENTS	48,753.05
COVERED CHARGES	968,704.75	CONTRACTUAL ALLOW	341,940.32
NON-COVERD CHARGES	14,879.75	TOTAL MEDICAID LIAB	626,764.43
		LESS: COB	8,252.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	618,511.63

TOTAL NUMBER OF ADMISSIONS 114

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	271	0	152,000.00	10,000.00
ROUTINE NURSERY	41	4	12,300.00	1,600.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	312	4	164,300.00	11,600.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	49	0	58,800.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	49	0	58,800.00	0.00
TOTAL ACCOMODATIONS	361	4	223,100.00	11,600.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	198,003.25	0.00
MED/SURG SUPPLY	66,536.17	64.75
LABORATORY-GENERAL	117,131.40	0.00
RADIOLOGY-DIAGNOSTIC	24,675.00	0.00
CT SCAN	64,675.00	0.00
PHYSICAL THERAPY	1,410.00	0.00
EKG/ECG	6,270.00	0.00
IV THERAPY	225.00	0.00
OPERATING ROOM	23,112.00	0.00
LABOR/DELIVERY ROOM	11,284.50	0.00
RESPIRATORY SERVICES	33,975.00	200.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,050.00	0.00
EMERGENCY ROOM	42,900.00	0.00
RECOVERY ROOM	1,897.50	0.00
LABORATORY PATHOLOGIC	2,059.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	570.00	0.00
SPEECH PATHOLOGY	640.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	50.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,050.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,097.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,100.00	1,290.00
AUDIOLOGY	560.00	0.00
CARDIOLOGY	14,318.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,775.13	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,050.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,100.00	1,025.00
PROFESSIONAL FEES	0.00	650.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	77,140.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	745,604.75	3,279.75
TOTAL ACCOMODATIONS	223,100.00	11,600.00
TOTAL CHARGES	968,704.75	14,879.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,169.30	ADJUSTMENTS	0.00
COVERED CHARGES	8,639.30	CONTRACTUAL ALLOW	198.78
NON-COVERD CHARGES	1,530.00	TOTAL MEDICAID LIAB	8,440.52
		LESS: COB	8,440.52
		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	3	0	1,800.00	0.00
ROUTINE NURSERY	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	1,800.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,800.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,428.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	880.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	313.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,530.00
OPERATING ROOM	1,932.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	687.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	194.25	0.00	INJECTABLE DRUGS	835.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	300.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,839.30	1,530.00
TOTAL ACCOMODATIONS	1,800.00	0.00
TOTAL CHARGES	8,639.30	1,530.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,343,432.94	ADJUSTMENTS	74,746.24
COVERED CHARGES	1,223,331.64	CONTRACTUAL ALLOW	831,868.39
NON-COVERD CHARGES	120,101.30	TOTAL MEDICAID LIAB	391,463.25
		LESS: COB	533.28
		LESS: COPAYMENT	1,890.00
		REIMBURSEMENT	389,039.97
		ALL OTHER	335,119.67
		FEE SCHEDULE-LAB	43,474.80
		INJECTABLE DRUGS	10,445.50

TOTAL NUMBER OF CLAIMS 1,418

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,309.21	14,572.75
MED/SURG SUPPLY	48,635.67	7,096.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	133,520.00	6,902.00
CT SCAN	176,575.00	3,775.00
PHYSICAL THERAPY	3,505.00	190.00
EKG/ECG	19,626.00	0.00
IV THERAPY	9,900.00	150.00
OPERATING ROOM	68,098.00	4,128.00
LABOR/DELIVERY ROOM	4,110.50	0.00
RESPIRATORY SERVICES	5,067.00	108.00
ANESTHESIA	0.00	0.00
GI SERVICES	9,150.00	0.00
EMERGENCY ROOM	189,850.00	3,350.00
RECOVERY ROOM	6,210.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,160.00	290.00
SPEECH PATHOLOGY	0.00	300.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,255.00	500.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	71,450.00	6,015.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,174.00	1,926.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,550.00	6,486.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,454.00	746.00
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/OBSERV. RM	13,199.61	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,350.00	600.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,850.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	214,489.90	38,843.00
MRI SERVICES	73,700.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	58,692.75	21,265.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	8.00

TOTAL ANCILLARY	1,223,331.64	120,101.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,223,331.64	120,101.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	1011123001093	04/19/11 - 04/19/11	06/06/11	0.00	8.00	0.00	0.00	0.00
TOTAL				0.00	8.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,374.45	ADJUSTMENTS	0.00
COVERED CHARGES	24,835.80	CONTRACTUAL ALLOW	-1,949.33
NON-COVERD CHARGES	7,538.65	TOTAL MEDICAID LIAB	26,785.13
		LESS: COB	26,758.13
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	978.50	25.00
MED/SURG SUPPLY	664.30	12.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,145.00	0.00
CT SCAN	4,875.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	825.00	0.00
IV THERAPY	225.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	415.00	0.00
RESPIRATORY SERVICES	56.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,450.00	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	50.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,350.00	725.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	327.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	600.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,530.00	520.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	3,525.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,044.40
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	345.00	336.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,835.80	7,538.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,835.80	7,538.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,685.91	ADJUSTMENTS	1,745.08
COVERED CHARGES	113,269.61	CONTRACTUAL ALLOW	102,283.87
NON-COVERD CHARGES	5,416.30	TOTAL MEDICAID LIAB	10,985.74
		LESS: COB	0.00
		LESS: COPAYMENT	351.01
		REIMBURSEMENT	10,634.73

TOTAL NUMBER OF CLAIMS 201

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,127.36	843.30	OTHER LAB	1,350.00	0.00
MED/SURG SUPPLY	1,443.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,605.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,450.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,363.00	2,076.00
EKG/ECG	1,650.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	560.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,590.00	500.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,352.25	847.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	700.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,550.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	201.00	450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	113,269.61	5,416.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	113,269.61	5,416.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
71	5911075001009	02/04/11 - 02/04/11	03/21/11	0.00	700.00	0.00	0.00	0.00
TOTAL				0.00	700.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,706.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,950.00	CONTRACTUAL ALLOW	678.64
NON-COVERD CHARGES	756.00	TOTAL MEDICAID LIAB	1,271.36
		LESS: COB	1,271.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.00	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	450.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,125.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35.00	250.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	450.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,950.00	756.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,950.00	756.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,132,236.95	ADJUSTMENTS	2,246,673.23
COVERED CHARGES	42,831,105.68	CONTRACTUAL ALLOW	29,906,548.87
NON-COVERD CHARGES	301,131.27	TOTAL MEDICAID LIAB	12,924,556.81
		LESS: COB	225,386.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,699,170.11

TOTAL NUMBER OF ADMISSIONS 1,270

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,118	0	2,090,564.00	55,916.00
ROUTINE NURSERY	742	0	672,089.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,860	0	2,762,653.00	55,916.00
SPECIAL CARE SERVICES				
CCU	325	0	510,250.00	0.00
ICU	3,427	0	3,558,440.00	4,560.00
NICU	435	0	682,950.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,187	0	4,751,640.00	4,560.00
TOTAL ACCOMODATIONS	10,047	0	7,514,293.00	60,476.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,628,490.31	15,562.95
MED/SURG SUPPLY	6,986,168.51	102,332.44
LABORATORY-GENERAL	4,767,265.82	7,827.00
RADIOLOGY-DIAGNOSTIC	1,227,910.00	11,914.00
CT SCAN	1,280,759.00	2,377.00
PHYSICAL THERAPY	268,036.00	0.00
EKG/ECG	278,345.00	229.00
IV THERAPY	254,431.00	8,882.00
OPERATING ROOM	2,202,328.00	14,748.00
LABOR/DELIVERY ROOM	288,843.00	0.00
RESPIRATORY SERVICES	1,801,265.00	9,334.00
ANESTHESIA	162,744.00	0.00
GI SERVICES	233,359.00	0.00
EMERGENCY ROOM	756,992.00	0.00
RECOVERY ROOM	148,975.00	0.00
LABORATORY PATHOLOGIC	193,280.00	0.00
RADIOLOGY THERAPEUTIC	6,000.00	0.00
OCCUPATIONAL THERAPY	79,605.00	0.00
SPEECH PATHOLOGY	115,555.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	165.00	4,454.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	250,245.00	52,087.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	375,820.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	140,727.00	0.00
AUDIOLOGY	21,777.00	228.00
CARDIOLOGY	1,321,800.00	1,998.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	23,295.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	278,820.00	4,924.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	213,109.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,245.00	0.00
OTHER THERAPEUTIC SVC	113,569.42	2,548.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	402,014.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	386.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,492,488.12	1,209.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,316,812.68	240,655.27
TOTAL ACCOMODATIONS	7,514,293.00	60,476.00
TOTAL CHARGES	42,831,105.68	301,131.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	238,634.07	ADJUSTMENTS	0.00
COVERED CHARGES	231,951.41	CONTRACTUAL ALLOW	113,455.65
NON-COVERD CHARGES	6,682.66	TOTAL MEDICAID LIAB	118,495.76
		LESS: COB	118,495.76
		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	44	0	23,104.00	1,536.00
ROUTINE NURSERY	3	0	3,471.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	26,575.00	1,536.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	2,820.00	0.00
NICU	4	0	6,280.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	9,100.00	0.00
TOTAL ACCOMODATIONS	54	0	35,675.00	1,536.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,269.45	637.66
MED/SURG SUPPLY	47,078.02	1,440.00
LABORATORY-GENERAL	27,773.00	389.00
RADIOLOGY-DIAGNOSTIC	234.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,177.00	0.00
OPERATING ROOM	15,822.00	0.00
LABOR/DELIVERY ROOM	31,233.00	2,418.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,448.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	947.00	0.00
RECOVERY ROOM	2,419.00	0.00
LABORATORY PATHOLOGIC	1,804.00	262.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	519.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,096.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	468.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	266.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	729.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	552.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,441.94	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	196,276.41	5,146.66
TOTAL ACCOMODATIONS	35,675.00	1,536.00
TOTAL CHARGES	231,951.41	6,682.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,891,854.90	ADJUSTMENTS	602,679.67
COVERED CHARGES	12,038,403.03	CONTRACTUAL ALLOW	9,257,761.15
NON-COVERD CHARGES	853,451.87	TOTAL MEDICAID LIAB	2,780,641.88
		LESS: COB	12,024.08
		LESS: COPAYMENT	10,666.57
		REIMBURSEMENT	2,757,951.23
		ALL OTHER	2,353,730.25
		FEE SCHEDULE-LAB	310,560.38
		INJECTABLE DRUGS	93,660.60

TOTAL NUMBER OF CLAIMS 9,403

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	753,495.37	1,980.29
MED/SURG SUPPLY	1,505,621.68	5,491.68
LABORATORY-GENERAL	0.00	32.00
RADIOLOGY-DIAGNOSTIC	657,253.00	9,288.00
CT SCAN	1,206,283.00	47,915.00
PHYSICAL THERAPY	4,368.00	2,851.00
EKG/ECG	224,156.00	0.00
IV THERAPY	259,113.00	0.00
OPERATING ROOM	570,401.84	85,872.16
LABOR/DELIVERY ROOM	66,347.00	0.00
RESPIRATORY SERVICES	173,222.00	27,951.00
ANESTHESIA	70,134.00	0.00
GI SERVICES	131,300.00	11,328.00
EMERGENCY ROOM	1,819,657.00	1,869.00
RECOVERY ROOM	112,492.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	7,414.00	0.00
OCCUPATIONAL THERAPY	9,407.00	1,702.00
SPEECH PATHOLOGY	966.00	2,898.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	180,511.00	14,687.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	273,579.00	8,530.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,490.00	576.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	184,350.00	0.00
AUDIOLOGY	1,718.00	0.00
CARDIOLOGY	346,062.00	88,588.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,529.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	590,803.00	2,275.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	178,794.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	2,873.00
OTHER THERAPEUTIC SVC	17.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,766,963.07	403,611.30
MRI SERVICES	306,535.00	8,799.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	50.00	170.00
FREE STANDING CLINIC	352.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	4,842.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	595,177.07	123,992.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	172.00

TOTAL ANCILLARY	12,038,403.03	853,451.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,038,403.03	853,451.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8294	5911285000830	03/08/11 - 03/08/11	10/17/11	0.00	32.00	0.00	0.00	0.00
9921	5912110001092	12/15/11 - 12/15/11	04/23/12	0.00	140.00	0.00	0.00	0.00
TOTAL				0.00	172.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,125.09	ADJUSTMENTS	0.00
COVERED CHARGES	96,170.04	CONTRACTUAL ALLOW	60,007.17
NON-COVERD CHARGES	21,955.05	TOTAL MEDICAID LIAB	36,162.87
		LESS: COB	36,093.24
		LESS: COPAYMENT	69.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,985.02	288.74
MED/SURG SUPPLY	13,571.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,163.00	0.00
CT SCAN	3,407.00	8,050.00
PHYSICAL THERAPY	0.00	352.00
EKG/ECG	1,832.00	0.00
IV THERAPY	1,860.00	0.00
OPERATING ROOM	9,076.00	5,838.00
LABOR/DELIVERY ROOM	1,356.00	0.00
RESPIRATORY SERVICES	131.00	0.00
ANESTHESIA	1,602.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,675.00	0.00
RECOVERY ROOM	3,238.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	792.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,616.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,268.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	943.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,925.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	750.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	157.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,859.00	3,728.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,063.21	2,598.31
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	96,170.04	21,955.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,170.04	21,955.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	410,415.34	ADJUSTMENTS	1,164.67
COVERED CHARGES	395,488.77	CONTRACTUAL ALLOW	360,358.45
NON-COVERD CHARGES	14,926.57	TOTAL MEDICAID LIAB	35,130.32
		LESS: COB	36.00
		LESS: COPAYMENT	1,380.11
		REIMBURSEMENT	33,714.21

TOTAL NUMBER OF CLAIMS 628

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,479.28	106.78
MED/SURG SUPPLY	26,544.32	239.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,258.00	570.00
CT SCAN	16,879.00	1,496.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,496.00	0.00
IV THERAPY	6,033.00	0.00
OPERATING ROOM	1,398.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,167.00	106.00
ANESTHESIA	132.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	205,571.00	0.00
RECOVERY ROOM	465.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	388.00	949.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	520.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,056.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	31,865.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	870.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	628.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	36,764.80	10,220.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,602.37	611.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	395,488.77	14,926.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	395,488.77	14,926.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	605.52	ADJUSTMENTS	0.00
COVERED CHARGES	605.52	CONTRACTUAL ALLOW	602.52
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	345.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	165.00	0.00			

TOTAL ANCILLARY	605.52	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	605.52	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,093,799.71	ADJUSTMENTS	153,069.79
COVERED CHARGES	1,882,877.15	CONTRACTUAL ALLOW	1,613,521.57
NON-COVERD CHARGES	210,922.56	TOTAL MEDICAID LIAB	269,355.58
		LESS: COB	0.00
		LESS: COPAYMENT	225.65
		REIMBURSEMENT	269,129.93

TOTAL NUMBER OF CLAIMS 51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,263.18	0.00
MED/SURG SUPPLY	808,961.15	4,568.00
LABORATORY-GENERAL	0.00	129.00
RADIOLOGY-DIAGNOSTIC	50,747.00	7,809.00
CT SCAN	9,210.00	3,628.00
PHYSICAL THERAPY	0.00	686.00
EKG/ECG	13,511.00	0.00
IV THERAPY	10,183.00	0.00
OPERATING ROOM	310,312.00	63,643.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	55.00	0.00
ANESTHESIA	6,570.00	0.00
GI SERVICES	825.00	0.00
EMERGENCY ROOM	2,841.00	0.00
RECOVERY ROOM	5,095.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,579.00	0.00
OCCUPATIONAL THERAPY	0.00	222.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	495.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,650.00	4,844.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	468.00	588.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,216.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	365,388.00	68,717.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	31,134.00	1,629.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	399.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,882.90	7,831.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	175,586.92	46,132.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,882,877.15	210,922.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,882,877.15	210,922.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,289,488.84	ADJUSTMENTS	539,392.54
COVERED CHARGES	9,221,621.81	CONTRACTUAL ALLOW	5,411,150.83
NON-COVERD CHARGES	67,867.03	TOTAL MEDICAID LIAB	3,810,470.98
		LESS: COB	34,145.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,776,325.56

TOTAL NUMBER OF ADMISSIONS 469

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,488	0	1,263,950.00	4,025.00
ROUTINE NURSERY	66	0	39,600.00	0.00
SWING BED	0	1	0.00	120.53
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,554	1	1,303,550.00	4,145.53
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	441	0	682,325.00	0.00
NICU	22	0	19,900.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	463	0	702,225.00	0.00
TOTAL ACCOMODATIONS	2,017	1	2,005,775.00	4,145.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	465,675.87	0.00
MED/SURG SUPPLY	1,097,983.40	11,522.00
LABORATORY-GENERAL	1,209,985.00	34.00
RADIOLOGY-DIAGNOSTIC	191,193.00	0.00
CT SCAN	408,196.00	8,181.00
PHYSICAL THERAPY	166,543.00	0.00
EKG/ECG	81,476.00	0.00
IV THERAPY	117,948.00	1,452.00
OPERATING ROOM	915,381.00	1,737.00
LABOR/DELIVERY ROOM	102,556.00	0.00
RESPIRATORY SERVICES	468,113.00	5,761.00
ANESTHESIA	40,764.00	0.00
GI SERVICES	93,797.00	0.00
EMERGENCY ROOM	414,254.00	322.00
RECOVERY ROOM	197,108.00	0.00
LABORATORY PATHOLOGIC	33,616.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,356.00	1,565.00
SPEECH PATHOLOGY	947.00	0.00
RENAL DIALYSIS	7,410.00	2,223.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	43,550.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	110,355.00	661.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,511.00	7,447.00
AUDIOLOGY	2,522.00	60.00
CARDIOLOGY	114,456.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,133.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	25,750.00	17,738.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	26,048.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	82,525.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	120.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,591.00
INJECTABLE DRUGS	731,574.54	3,427.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,215,846.81	63,721.50
TOTAL ACCOMODATIONS	2,005,775.00	4,145.53
TOTAL CHARGES	9,221,621.81	67,867.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,169.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,169.00	CONTRACTUAL ALLOW	14,752.62
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	24,416.38
		LESS: COB	24,416.38
		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	10	0	8,500.00	0.00
ROUTINE NURSERY	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	8,500.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	10	0	8,500.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,639.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,110.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,884.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,804.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,603.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	580.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	842.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,608.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	377.00	0.00	INJECTABLE DRUGS	2,049.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,904.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	30,669.00	0.00
TOTAL ACCOMODATIONS	8,500.00	0.00
TOTAL CHARGES	39,169.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,636,398.00	ADJUSTMENTS	414,727.13
COVERED CHARGES	9,085,432.55	CONTRACTUAL ALLOW	7,221,814.73
NON-COVERD CHARGES	550,965.45	TOTAL MEDICAID LIAB	1,863,617.82
		LESS: COB	0.00
		LESS: COPAYMENT	3,847.79
		REIMBURSEMENT	1,859,770.03
		ALL OTHER	1,630,178.74
		FEE SCHEDULE-LAB	188,359.55
		INJECTABLE DRUGS	41,231.74

TOTAL NUMBER OF CLAIMS 4,715

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,281.28	207.00
MED/SURG SUPPLY	396,605.15	529.00
LABORATORY-GENERAL	0.00	108.00
RADIOLOGY-DIAGNOSTIC	603,817.00	9,888.00
CT SCAN	1,218,718.00	46,834.00
PHYSICAL THERAPY	24,890.00	2,496.00
EKG/ECG	159,863.00	1,589.00
IV THERAPY	420,214.00	45,005.00
OPERATING ROOM	546,320.00	84,426.00
LABOR/DELIVERY ROOM	36,160.00	0.00
RESPIRATORY SERVICES	27,541.00	1,663.00
ANESTHESIA	29,490.00	0.00
GI SERVICES	85,717.00	11,977.00
EMERGENCY ROOM	2,154,314.00	18,599.00
RECOVERY ROOM	144,320.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	22,292.00	0.00
OCCUPATIONAL THERAPY	10,918.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,482.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,267.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	203,208.00	8,521.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,512.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	135,350.00	288.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	101,488.00	3,249.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	50,458.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	252,816.00	4,898.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	57,645.00	387.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,705,959.88	231,808.95
MRI SERVICES	231,656.00	6,850.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	4,560.00	990.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	257,052.24	68,903.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	267.00

TOTAL ANCILLARY	9,085,432.55	550,965.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,085,432.55	550,965.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
948	2211291005097	06/23/11 - 06/23/11	10/24/11	0.00	165.00	0.00	0.00	0.00
8573	2212179004816	12/30/11 - 12/30/11	07/02/12	0.00	102.00	0.00	0.00	0.00
TOTAL				0.00	267.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	121,556.50	ADJUSTMENTS	0.00
COVERED CHARGES	108,167.00	CONTRACTUAL ALLOW	54,750.11
NON-COVERD CHARGES	13,389.50	TOTAL MEDICAID LIAB	53,416.89
		LESS: COB	53,404.89
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,584.00	0.00
MED/SURG SUPPLY	3,108.00	26.00
LABORATORY-GENERAL	0.00	38.00
RADIOLOGY-DIAGNOSTIC	7,338.00	0.00
CT SCAN	14,439.00	6,437.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,090.00	0.00
IV THERAPY	5,346.00	373.00
OPERATING ROOM	4,445.00	0.00
LABOR/DELIVERY ROOM	1,068.00	0.00
RESPIRATORY SERVICES	66.00	0.00
ANESTHESIA	290.00	0.00
GI SERVICES	0.00	2,396.00
EMERGENCY ROOM	31,404.00	842.00
RECOVERY ROOM	1,804.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,448.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,975.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,422.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,211.00	5.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,674.25	2,750.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	217.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,454.75	305.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	108,167.00	13,389.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	108,167.00	13,389.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	846,085.75	ADJUSTMENTS	3,243.39
COVERED CHARGES	819,106.25	CONTRACTUAL ALLOW	788,197.57
NON-COVERD CHARGES	26,979.50	TOTAL MEDICAID LIAB	30,908.68
		LESS: COB	49.94
		LESS: COPAYMENT	1,401.04
		REIMBURSEMENT	29,457.70

TOTAL NUMBER OF CLAIMS 732

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,642.75	33.00
MED/SURG SUPPLY	28,775.75	10.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,479.00	828.00
CT SCAN	55,230.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,583.00	0.00
IV THERAPY	27,817.00	847.00
OPERATING ROOM	0.00	3,402.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	674.00	0.00
ANESTHESIA	290.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	456,355.00	1,011.00
RECOVERY ROOM	1,804.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,379.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	345.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,036.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	143,241.00	10,146.00
MRI SERVICES	3,033.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,421.75	10,702.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	819,106.25	26,979.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	819,106.25	26,979.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,441.50	ADJUSTMENTS	0.00
COVERED CHARGES	24,873.00	CONTRACTUAL ALLOW	14,120.07
NON-COVERD CHARGES	568.50	TOTAL MEDICAID LIAB	10,752.93
		LESS: COB	10,734.93
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	604.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	663.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,030.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,430.00	105.00
EKG/ECG	227.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	539.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,741.00	22.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	250.50	22.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	418.00	419.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,873.00	568.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,873.00	568.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	325,924.80	ADJUSTMENTS	34,100.56
COVERED CHARGES	312,792.30	CONTRACTUAL ALLOW	250,304.90
NON-COVERD CHARGES	13,132.50	TOTAL MEDICAID LIAB	62,487.40
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	62,370.40

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,556.25	0.00
MED/SURG SUPPLY	36,788.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,927.00	0.00
CT SCAN	3,683.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,816.00	0.00
IV THERAPY	39,255.00	1,965.00
OPERATING ROOM	61,998.00	1.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	39,065.00	0.00
ANESTHESIA	2,855.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,202.00	0.00
RECOVERY ROOM	12,628.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,521.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,436.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,083.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,088.00	917.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,682.00	1,563.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,208.25	8,686.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	312,792.30	13,132.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	312,792.30	13,132.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER
PO BOX 1059
THOMASTON,GA 30286-0027

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,112,299.62	ADJUSTMENTS	320,853.07
COVERED CHARGES	4,080,724.51	CONTRACTUAL ALLOW	3,134,136.59
NON-COVERD CHARGES	31,575.11	TOTAL MEDICAID LIAB	946,587.92
		LESS: COB	11,744.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	934,843.14

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	212	0	204,792.00	16,536.00
ROUTINE NURSERY	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	212	0	204,792.00	16,536.00
SPECIAL CARE SERVICES				
CCU	670	0	1,150,088.00	0.00
ICU	14	0	36,400.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	684	0	1,186,488.00	0.00
TOTAL ACCOMODATIONS	896	0	1,391,280.00	16,536.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	529,095.75	141.75
MED/SURG SUPPLY	173,692.00	1,375.36
LABORATORY-GENERAL	370,371.00	0.00
RADIOLOGY-DIAGNOSTIC	69,546.00	0.00
CT SCAN	81,623.00	0.00
PHYSICAL THERAPY	55,362.00	0.00
EKG/ECG	5,294.00	0.00
IV THERAPY	38,421.00	8,740.00
OPERATING ROOM	70,143.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	980,669.00	376.00
ANESTHESIA	5,885.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,862.00	0.00
LABORATORY PATHOLOGIC	4,435.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	33,803.00	0.00
SPEECH PATHOLOGY	49,377.00	0.00
RENAL DIALYSIS	130,608.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,135.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,446.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,241.00	46.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,775.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,813.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,656.76	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	15,440.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	25.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,360.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,678.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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 LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,689,444.51	15,039.11
TOTAL ACCOMODATIONS	1,391,280.00	16,536.00
TOTAL CHARGES	4,080,724.51	31,575.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	835,112.25	ADJUSTMENTS	85,543.36
COVERED CHARGES	800,443.25	CONTRACTUAL ALLOW	514,104.20
NON-COVERD CHARGES	34,669.00	TOTAL MEDICAID LIAB	286,339.05
		LESS: COB	1,849.37
		LESS: COPAYMENT	1,257.00
		REIMBURSEMENT	283,232.68
		ALL OTHER	281,620.42
		FEE SCHEDULE-LAB	1,612.26
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 304

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,093.25	0.00	OTHER LAB	3,338.00	0.00
MED/SURG SUPPLY	21,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,120.00	3,531.00
RADIOLOGY-DIAGNOSTIC	30,154.00	1,501.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,578.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,447.00	2,417.00	FEE SCHEDULE LAB	17,259.00	923.00
EKG/ECG	1,036.00	0.00	MRI SERVICES	42,584.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,436.00	13,597.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,393.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,275.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,397.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	196,394.00	770.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	37,084.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,421.00	10,926.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	245,169.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	930.00	1,004.00			

TOTAL ANCILLARY	800,443.25	34,669.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	800,443.25	34,669.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,771.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,771.00	CONTRACTUAL ALLOW	4,565.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,205.36
		LESS: COB	1,199.36
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,436.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,287.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,771.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,771.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	227,077.95	ADJUSTMENTS	20,838.84
COVERED CHARGES	223,713.95	CONTRACTUAL ALLOW	176,799.56
NON-COVERD CHARGES	3,364.00	TOTAL MEDICAID LIAB	46,914.39
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	46,881.39

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,214.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32,388.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,540.00	2,434.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,559.00	0.00
EKG/ECG	207.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,210.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,286.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	92,576.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,391.70	930.00			

TOTAL ANCILLARY	223,713.95	3,364.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	223,713.95	3,364.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL
PO BOX 406173
ATLANTA,GA 30384-6173

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,183,302.28	ADJUSTMENTS	186,753.84
COVERED CHARGES	7,119,696.05	CONTRACTUAL ALLOW	3,860,072.16
NON-COVERD CHARGES	63,606.23	TOTAL MEDICAID LIAB	3,259,623.89
		LESS: COB	8,075.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,251,548.21

TOTAL NUMBER OF ADMISSIONS 656

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,405	8	752,119.00	37,155.00
ROUTINE NURSERY	373	0	170,218.01	336.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,778	8	922,337.01	37,491.00
SPECIAL CARE SERVICES				
CCU	268	0	220,832.00	0.00
ICU	208	0	238,368.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	476	0	459,200.00	0.00
TOTAL ACCOMODATIONS	2,254	8	1,381,537.01	37,491.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,083,890.67	0.00
MED/SURG SUPPLY	782,762.48	2,884.23
LABORATORY-GENERAL	950,898.75	710.00
RADIOLOGY-DIAGNOSTIC	134,492.00	0.00
CT SCAN	231,951.00	0.00
PHYSICAL THERAPY	28,267.00	0.00
EKG/ECG	42,380.00	0.00
IV THERAPY	63,132.00	0.00
OPERATING ROOM	589,253.00	0.00
LABOR/DELIVERY ROOM	166,768.00	0.00
RESPIRATORY SERVICES	286,052.00	0.00
ANESTHESIA	84,528.00	0.00
GI SERVICES	54,366.00	0.00
EMERGENCY ROOM	149,501.00	0.00
RECOVERY ROOM	77,846.00	0.00
LABORATORY PATHOLOGIC	47,549.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	471.00	0.00
SPEECH PATHOLOGY	3,577.00	0.00
RENAL DIALYSIS	556.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	190.00	11,957.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	31,255.00	0.00
BLOOD	1,320.00	0.00
BLOOD STORAGE & PRO.	63,964.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,043.00	6,388.00
AUDIOLOGY	14,362.00	0.00
CARDIOLOGY	87,445.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,330.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	58,146.00	4,116.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,776.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,381.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,551.00	0.00
PROFESSIONAL FEES	0.00	60.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	632,154.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,738,159.04	26,115.23
TOTAL ACCOMODATIONS	1,381,537.01	37,491.00
TOTAL CHARGES	7,119,696.05	63,606.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,076.15	ADJUSTMENTS	0.00
COVERED CHARGES	29,872.15	CONTRACTUAL ALLOW	13,907.32
NON-COVERD CHARGES	204.00	TOTAL MEDICAID LIAB	15,964.83
		LESS: COB	15,964.83
		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	4	0	2,280.00	204.00
ROUTINE NURSERY	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	2,280.00	204.00
SPECIAL CARE SERVICES				
CCU	5	0	4,120.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,120.00	0.00
TOTAL ACCOMODATIONS	9	0	6,400.00	204.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,291.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,359.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,845.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	172.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,256.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	339.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,946.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	628.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,174.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	460.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,472.15	0.00
TOTAL ACCOMODATIONS	6,400.00	204.00
TOTAL CHARGES	29,872.15	204.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,652,506.82	ADJUSTMENTS	262,951.87
COVERED CHARGES	5,041,991.88	CONTRACTUAL ALLOW	3,519,927.35
NON-COVERD CHARGES	610,514.94	TOTAL MEDICAID LIAB	1,522,064.53
		LESS: COB	1,615.02
		LESS: COPAYMENT	7,125.74
		REIMBURSEMENT	1,513,323.77
		ALL OTHER	1,288,192.52
		FEE SCHEDULE-LAB	164,949.50
		INJECTABLE DRUGS	60,181.75

TOTAL NUMBER OF CLAIMS 5,365

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205,371.94	13,524.23
MED/SURG SUPPLY	177,237.99	66,579.41
LABORATORY-GENERAL	0.00	42.00
RADIOLOGY-DIAGNOSTIC	279,339.00	14,541.00
CT SCAN	636,776.00	34,438.00
PHYSICAL THERAPY	38,289.00	5,090.00
EKG/ECG	53,148.00	163.00
IV THERAPY	130,807.00	13,922.00
OPERATING ROOM	362,925.00	35,442.00
LABOR/DELIVERY ROOM	11,368.00	0.00
RESPIRATORY SERVICES	32,711.00	4,454.00
ANESTHESIA	57,600.00	0.00
GI SERVICES	176,089.00	12,281.00
EMERGENCY ROOM	675,292.00	2,904.00
RECOVERY ROOM	48,013.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	18,842.00	0.00
OCCUPATIONAL THERAPY	2,619.00	929.00
SPEECH PATHOLOGY	5,951.00	1,161.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	197,061.38	16,213.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	224,953.00	11,422.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,536.00	3,808.00
ONCOLOGY	255.00	0.00
NUCLEAR MEDICINE	176,332.00	31,526.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	180,215.00	40,454.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,299.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	112,881.00	5,947.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	44,871.00	423.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	282.00	220.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	661,380.25	169,441.63
MRI SERVICES	221,491.00	2,080.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	8,259.12
INJECTABLE DRUGS	236,056.32	115,250.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,041,991.88	610,514.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,041,991.88	610,514.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,009.77	ADJUSTMENTS	0.00
COVERED CHARGES	40,658.91	CONTRACTUAL ALLOW	8,876.42
NON-COVERD CHARGES	11,350.86	TOTAL MEDICAID LIAB	31,782.49
		LESS: COB	31,748.70
		LESS: COPAYMENT	33.79
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE IV
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,387.20	0.00
MED/SURG SUPPLY	2,132.15	1,566.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,423.00	172.00
CT SCAN	7,550.00	3,828.00
PHYSICAL THERAPY	0.00	326.00
EKG/ECG	815.00	0.00
IV THERAPY	1,575.00	143.00
OPERATING ROOM	3,547.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	174.00	0.00
ANESTHESIA	720.00	0.00
GI SERVICES	2,146.00	0.00
EMERGENCY ROOM	6,277.00	0.00
RECOVERY ROOM	439.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	795.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,266.00	407.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	869.00	1,847.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,156.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,875.00	1,624.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	120.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	512.56	1,314.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	3.03

TOTAL ANCILLARY	40,658.91	11,350.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,658.91	11,350.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
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PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
25	1112088003751	08/07/11 - 08/07/11	04/02/12	0.00	3.03	0.00	113.98	0.00
TOTAL				0.00	3.03	0.00	113.98	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
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SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	243,465.56	ADJUSTMENTS	902.95
COVERED CHARGES	236,505.48	CONTRACTUAL ALLOW	210,684.96
NON-COVERD CHARGES	6,960.08	TOTAL MEDICAID LIAB	25,820.52
		LESS: COB	20.22
		LESS: COPAYMENT	828.07
		REIMBURSEMENT	24,972.23

TOTAL NUMBER OF CLAIMS 462

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,043.73	631.62
MED/SURG SUPPLY	2,999.30	890.70
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,030.00	320.00
CT SCAN	22,448.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,304.00	0.00
IV THERAPY	3,372.00	286.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	602.00	222.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	130,020.00	329.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	862.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	740.00	35.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,240.00	333.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	194.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	639.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,025.00	2,399.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,625.45	873.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	236,505.48	6,960.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	236,505.48	6,960.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,013.19	ADJUSTMENTS	0.00
COVERED CHARGES	4,920.15	CONTRACTUAL ALLOW	4,426.59
NON-COVERD CHARGES	93.04	TOTAL MEDICAID LIAB	493.56
		LESS: COB	493.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
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SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	451.13	21.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	70.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	773.50	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,272.00	0.00
IV THERAPY	269.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,063.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.52	21.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,920.15	93.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,920.15	93.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	763,201.76	ADJUSTMENTS	55,201.52
COVERED CHARGES	703,999.75	CONTRACTUAL ALLOW	553,150.94
NON-COVERD CHARGES	59,202.01	TOTAL MEDICAID LIAB	150,848.81
		LESS: COB	0.00
		LESS: COPAYMENT	369.19
		REIMBURSEMENT	150,479.62

TOTAL NUMBER OF CLAIMS 30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,088.63	1,355.94
MED/SURG SUPPLY	37,085.38	4,701.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,641.00	584.00
CT SCAN	17,599.00	3,828.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	489.00	0.00
IV THERAPY	20,657.00	395.00
OPERATING ROOM	41,858.00	0.00
LABOR/DELIVERY ROOM	1,473.00	0.00
RESPIRATORY SERVICES	139.00	0.00
ANESTHESIA	6,799.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,711.00	0.00
RECOVERY ROOM	3,525.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	27,614.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,879.00	164.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,777.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,481.00	1,358.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,299.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,256.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,146.00	2,300.00
MRI SERVICES	2,537.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	464,945.74	44,516.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	703,999.75	59,202.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	703,999.75	59,202.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
PO BOX 40
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,813,731.19	ADJUSTMENTS	1,248,125.17
COVERED CHARGES	10,763,713.74	CONTRACTUAL ALLOW	4,056,454.46
NON-COVERD CHARGES	1,050,017.45	TOTAL MEDICAID LIAB	6,707,259.28
		LESS: COB	2,882.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,704,376.94

TOTAL NUMBER OF ADMISSIONS 1,533

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,716	120	5,621,292.00	946,075.00
ROUTINE NURSERY	137	0	72,610.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,853	120	5,693,902.00	946,075.00
SPECIAL CARE SERVICES				
CCU	172	0	226,268.00	0.00
ICU	132	0	279,840.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	304	0	506,108.00	0.00
TOTAL ACCOMODATIONS	7,157	120	6,200,010.00	946,075.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,356,127.41	0.00
MED/SURG SUPPLY	269,402.31	441.98
LABORATORY-GENERAL	1,307,859.00	108.00
RADIOLOGY-DIAGNOSTIC	68,040.00	0.00
CT SCAN	135,918.00	980.00
PHYSICAL THERAPY	19,504.00	0.00
EKG/ECG	27,830.00	0.00
IV THERAPY	7,460.00	0.00
OPERATING ROOM	201,031.00	0.00
LABOR/DELIVERY ROOM	138,858.00	0.00
RESPIRATORY SERVICES	185,725.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	15,984.00	0.00
EMERGENCY ROOM	155,385.00	343.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	19,915.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	5,786.00	0.00
RENAL DIALYSIS	0.00	62,656.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,012.00	147.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,590.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	52,050.00	11,710.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,919.00	0.00
AUDIOLOGY	4,898.00	0.00
CARDIOLOGY	129,481.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,270.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,664.00	490.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,534.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	672.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	24,400.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	27,066.47
INJECTABLE DRUGS	327,389.02	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,563,703.74	103,942.45
TOTAL ACCOMODATIONS	6,200,010.00	946,075.00
TOTAL CHARGES	10,763,713.74	1,050,017.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,188.71	ADJUSTMENTS	0.00
COVERED CHARGES	23,187.71	CONTRACTUAL ALLOW	7,802.15
NON-COVERD CHARGES	1,001.00	TOTAL MEDICAID LIAB	15,385.56
		LESS: COB	15,385.56
		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	9	0	7,533.00	1,001.00
ROUTINE NURSERY	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	7,533.00	1,001.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	9	0	7,533.00	1,001.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,644.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,717.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,895.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,705.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	242.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	372.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	79.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,654.71	0.00
TOTAL ACCOMODATIONS	7,533.00	1,001.00
TOTAL CHARGES	23,187.71	1,001.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,609,151.85	ADJUSTMENTS	653,521.86
COVERED CHARGES	7,874,987.79	CONTRACTUAL ALLOW	5,572,215.49
NON-COVERD CHARGES	734,164.06	TOTAL MEDICAID LIAB	2,302,772.30
		LESS: COB	729.56
		LESS: COPAYMENT	6,492.00
		REIMBURSEMENT	2,295,550.74
		ALL OTHER	2,015,924.04
		FEE SCHEDULE-LAB	181,773.73
		INJECTABLE DRUGS	97,852.97

TOTAL NUMBER OF CLAIMS 4,770

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	244,215.49	3,306.77
MED/SURG SUPPLY	199,469.10	3,813.48
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	355,916.00	6,193.00
CT SCAN	801,270.00	86,949.00
PHYSICAL THERAPY	0.00	1,097.00
EKG/ECG	74,610.00	3,000.00
IV THERAPY	113,494.09	2,217.00
OPERATING ROOM	339,285.00	54,785.00
LABOR/DELIVERY ROOM	11,255.00	0.00
RESPIRATORY SERVICES	37,319.00	3,377.00
ANESTHESIA	0.00	0.00
GI SERVICES	75,036.00	12,876.00
EMERGENCY ROOM	1,056,482.57	19,944.34
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	26,226.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	861.00	1,202.00
PSYCHIATRIC SERVICES	1,715,780.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	215,923.00	22,600.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,500.00	4,764.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	187,627.00	21,833.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	65,641.00	15,767.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	98,645.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	74,674.00	5,179.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,754.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	727.00	300.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,563,480.10	309,567.30
MRI SERVICES	281,560.00	9,080.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	254,237.44	146,313.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,874,987.79	734,164.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,874,987.79	734,164.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,029.32	ADJUSTMENTS	0.00
COVERED CHARGES	25,935.32	CONTRACTUAL ALLOW	14,783.08
NON-COVERD CHARGES	1,094.00	TOTAL MEDICAID LIAB	11,152.24
		LESS: COB	11,146.24
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,404.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	788.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	225.00
RADIOLOGY-DIAGNOSTIC	540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,925.00	289.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	46.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,050.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	407.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	228.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,630.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	566.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,450.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,935.32	1,094.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,935.32	1,094.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	434,289.83	ADJUSTMENTS	6,823.86
COVERED CHARGES	416,450.33	CONTRACTUAL ALLOW	377,691.74
NON-COVERD CHARGES	17,839.50	TOTAL MEDICAID LIAB	38,758.59
		LESS: COB	0.00
		LESS: COPAYMENT	1,254.02
		REIMBURSEMENT	37,504.57

TOTAL NUMBER OF CLAIMS 696

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,297.83	73.05
MED/SURG SUPPLY	8,418.33	58.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,590.00	450.00
CT SCAN	13,400.00	3,600.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,200.00	200.00
IV THERAPY	2,059.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	94.00	0.00
RESPIRATORY SERVICES	1,769.00	242.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,332.00	0.00
EMERGENCY ROOM	238,372.64	3,614.36
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,270.00	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	73,859.00	8,553.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,188.53	1,049.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	416,450.33	17,839.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	416,450.33	17,839.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,721.67	ADJUSTMENTS	0.00
COVERED CHARGES	4,702.67	CONTRACTUAL ALLOW	4,121.05
NON-COVERD CHARGES	1,019.00	TOTAL MEDICAID LIAB	581.62
		LESS: COB	575.62
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,703.00	1,019.00
EKG/ECG	200.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,481.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,702.67	1,019.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,702.67	1,019.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	510,573.98	ADJUSTMENTS	51,433.08
COVERED CHARGES	462,101.54	CONTRACTUAL ALLOW	328,478.53
NON-COVERD CHARGES	48,472.44	TOTAL MEDICAID LIAB	133,623.01
		LESS: COB	0.00
		LESS: COPAYMENT	147.00
		REIMBURSEMENT	133,476.01

TOTAL NUMBER OF CLAIMS 24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,241.27	708.24	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	93,676.82	157.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,034.00	2,625.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,400.00	3,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	459.00	FEE SCHEDULE LAB	11,290.00	2,166.70
EKG/ECG	1,600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,370.00	276.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,590.50	36,644.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,089.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,798.09	646.91	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,071.86	621.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	138.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	180,895.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,200.00	930.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,158.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,687.00	0.00			

TOTAL ANCILLARY	462,101.54	48,472.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	462,101.54	48,472.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,216,777.59	ADJUSTMENTS	89,937.40
COVERED CHARGES	1,199,815.19	CONTRACTUAL ALLOW	754,838.46
NON-COVERD CHARGES	16,962.40	TOTAL MEDICAID LIAB	444,976.73
		LESS: COB	2,693.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	442,283.63

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	163	0	62,342.30	774.80
ROUTINE NURSERY	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	163	0	62,342.30	774.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	56	0	73,528.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	56	0	73,528.00	0.00
TOTAL ACCOMODATIONS	219	0	135,870.30	774.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270,740.43	0.00
MED/SURG SUPPLY	187,162.65	0.00
LABORATORY-GENERAL	139,534.16	0.00
RADIOLOGY-DIAGNOSTIC	19,676.35	0.00
CT SCAN	23,060.91	1,471.80
PHYSICAL THERAPY	10,219.40	0.00
EKG/ECG	19,362.25	0.00
IV THERAPY	51,895.25	0.00
OPERATING ROOM	65,517.35	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	121,542.25	0.00
ANESTHESIA	17,776.35	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	77,995.20	0.00
RECOVERY ROOM	11,319.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,253.75	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,701.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,314.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,491.80	93.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,914.75	0.00
AMBULATORY SURGERY	1,042.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	727.65	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,946.45	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,574.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	14,622.10
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,465.59	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,710.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,063,944.89	16,187.60
TOTAL ACCOMODATIONS	135,870.30	774.80
TOTAL CHARGES	1,199,815.19	16,962.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,384,904.75	ADJUSTMENTS	107,643.14
COVERED CHARGES	2,193,640.03	CONTRACTUAL ALLOW	1,731,663.05
NON-COVERD CHARGES	191,264.72	TOTAL MEDICAID LIAB	461,976.98
		LESS: COB	67.61
		LESS: COPAYMENT	3,204.00
		REIMBURSEMENT	458,705.37
		ALL OTHER	408,195.22
		FEE SCHEDULE-LAB	50,475.15
		INJECTABLE DRUGS	35.00
		TOTAL NUMBER OF CLAIMS	2,202

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,746.85	208.50
MED/SURG SUPPLY	205,923.88	32,401.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,908.50	4,799.00
CT SCAN	110,111.05	12,497.02
PHYSICAL THERAPY	2,538.35	684.60
EKG/ECG	49,402.60	1,609.85
IV THERAPY	48,683.95	613.20
OPERATING ROOM	249,106.65	24,594.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27,815.45	3,381.70
ANESTHESIA	80,905.40	3,403.10
GI SERVICES	0.00	0.00
EMERGENCY ROOM	483,439.24	153.30
RECOVERY ROOM	71,441.20	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	16,691.40	1,462.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	33,319.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	999.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,192.30	3,627.55
AUDIOLOGY	1,282.90	303.90
CARDIOLOGY	52,374.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,272.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,742.25	517.60

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	22,614.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	397.90	10,907.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	357,226.59	81,737.26
MRI SERVICES	55,669.02	862.64
PROFESSIONAL FEES	0.00	1,950.95
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	833.20	5,548.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,193,640.03	191,264.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,193,640.03	191,264.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,896.25	ADJUSTMENTS	0.00
COVERED CHARGES	8,725.36	CONTRACTUAL ALLOW	6,066.71
NON-COVERD CHARGES	1,170.89	TOTAL MEDICAID LIAB	2,658.65
		LESS: COB	2,654.31
		LESS: COPAYMENT	4.34
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	210.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,671.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	213.70	0.00	FEE SCHEDULE LAB	1,933.97	308.25
EKG/ECG	343.90	0.00	MRI SERVICES	862.64	862.64
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,151.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,725.36	1,170.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,725.36	1,170.89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	135,164.61	ADJUSTMENTS	1,718.08
COVERED CHARGES	130,836.51	CONTRACTUAL ALLOW	120,263.85
NON-COVERD CHARGES	4,328.10	TOTAL MEDICAID LIAB	10,572.66
		LESS: COB	0.00
		LESS: COPAYMENT	378.00
		REIMBURSEMENT	10,194.66

TOTAL NUMBER OF CLAIMS 189

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,812.09	0.00	OTHER LAB	623.95	0.00
MED/SURG SUPPLY	3,638.90	156.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,261.15	0.00	OTHER THERAPEUTIC SVC	0.00	1,348.70
CT SCAN	1,908.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,173.82	2,310.75
EKG/ECG	877.55	171.95	MRI SERVICES	0.00	0.00
IV THERAPY	2,381.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,860.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,360.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	340.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,057.35	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/OBSERV. RM	881.45	0.00			

TOTAL ANCILLARY	130,836.51	4,328.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	130,836.51	4,328.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,312.35	ADJUSTMENTS	4,807.43
COVERED CHARGES	83,572.70	CONTRACTUAL ALLOW	64,466.00
NON-COVERD CHARGES	3,739.65	TOTAL MEDICAID LIAB	19,106.70
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	19,085.70

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,821.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,684.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	476.15	OTHER THERAPEUTIC SVC	0.00	1,839.60
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	768.25	19.00
EKG/ECG	180.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,576.25	153.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,853.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	779.75	452.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,554.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,843.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	690.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	109.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,585.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	924.80	0.00			

TOTAL ANCILLARY	83,572.70	3,739.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,572.70	3,739.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
PO BOX 2239
ELLIJAY,GA 30540-0025

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,620,976.08	ADJUSTMENTS	336,957.46
COVERED CHARGES	5,583,777.08	CONTRACTUAL ALLOW	3,588,505.87
NON-COVERD CHARGES	37,199.00	TOTAL MEDICAID LIAB	1,995,271.21
		LESS: COB	10,715.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,984,556.02

TOTAL NUMBER OF ADMISSIONS 332

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,171	0	489,444.00	23,793.00
ROUTINE NURSERY	100	0	25,900.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,271	0	515,344.00	23,793.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	237	0	242,639.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	237	0	242,639.00	0.00
TOTAL ACCOMODATIONS	1,508	0	757,983.00	23,793.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,373,821.00	0.00
MED/SURG SUPPLY	1,190,591.20	712.00
LABORATORY-GENERAL	792,090.00	448.00
RADIOLOGY-DIAGNOSTIC	95,331.04	979.00
CT SCAN	251,772.50	0.00
PHYSICAL THERAPY	30,846.00	0.00
EKG/ECG	31,448.00	0.00
IV THERAPY	7,019.00	0.00
OPERATING ROOM	299,028.00	0.00
LABOR/DELIVERY ROOM	38,784.67	0.00
RESPIRATORY SERVICES	117,604.00	417.00
ANESTHESIA	35,192.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	187,971.00	802.00
RECOVERY ROOM	22,499.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,748.00	0.00
SPEECH PATHOLOGY	4,232.00	0.00
RENAL DIALYSIS	8,478.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	7,320.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	15,205.00	0.00
OTHER IMAGING SERVICE	22,458.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,743.00	1,025.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,494.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	64,523.00	0.00
AMBULATORY SURGERY	3,820.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	76,692.67	1,605.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	20,391.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	98.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	65,535.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,477.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,825,794.08	13,406.00
TOTAL ACCOMODATIONS	757,983.00	23,793.00
TOTAL CHARGES	5,583,777.08	37,199.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,579.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,537.00	CONTRACTUAL ALLOW	2,963.90
NON-COVERD CHARGES	42.00	TOTAL MEDICAID LIAB	4,573.10
		LESS: COB	4,573.10
		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	2	0	836.00	42.00
ROUTINE NURSERY	2	0	518.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,354.00	42.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,354.00	42.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,328.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,679.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	951.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	84.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,141.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,183.00	0.00
TOTAL ACCOMODATIONS	1,354.00	42.00
TOTAL CHARGES	7,537.00	42.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,247,830.51	ADJUSTMENTS	431,624.46
COVERED CHARGES	3,838,510.71	CONTRACTUAL ALLOW	2,744,528.58
NON-COVERD CHARGES	409,319.80	TOTAL MEDICAID LIAB	1,093,982.13
		LESS: COB	877.47
		LESS: COPAYMENT	3,312.00
		REIMBURSEMENT	1,089,792.66
		ALL OTHER	984,913.15
		FEE SCHEDULE-LAB	99,159.80
		INJECTABLE DRUGS	5,719.71

TOTAL NUMBER OF CLAIMS 3,334

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247,355.76	3,632.00
MED/SURG SUPPLY	500,656.00	1,740.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173,222.72	3,488.00
CT SCAN	486,669.00	104,587.00
PHYSICAL THERAPY	13,029.00	4,212.00
EKG/ECG	39,277.00	0.00
IV THERAPY	21,679.00	0.00
OPERATING ROOM	310,398.00	37,946.00
LABOR/DELIVERY ROOM	16,272.00	217.00
RESPIRATORY SERVICES	14,911.00	598.00
ANESTHESIA	37,686.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	757,691.00	1,315.00
RECOVERY ROOM	32,711.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,580.00	911.00
SPEECH PATHOLOGY	308.00	237.00
RENAL DIALYSIS	0.00	471.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	15,000.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	31,091.00	16,624.00
OTHER IMAGING SERVICE	106,421.00	12,004.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,989.00	612.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,159.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,981.00	1,383.00
AMBULATORY SURGERY	955.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	83,423.00	1,446.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	18,994.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	671,743.23	149,749.80
MRI SERVICES	154,389.00	7,349.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40,920.00	60,798.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,838,510.71	409,319.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,838,510.71	409,319.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,701.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,608.00	CONTRACTUAL ALLOW	19,009.88
NON-COVERD CHARGES	11,093.00	TOTAL MEDICAID LIAB	20,598.12
		LESS: COB	20,583.12
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,397.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,012.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	247.00	161.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,455.00	4,395.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,237.00	1,031.00
EKG/ECG	121.00	121.00	MRI SERVICES	0.00	0.00
IV THERAPY	36.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,794.00	3,612.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	217.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,555.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,024.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391.00	277.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	278.00	1,496.00			

TOTAL ANCILLARY	39,608.00	11,093.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,608.00	11,093.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	341,004.00	ADJUSTMENTS	7,153.12
COVERED CHARGES	316,279.00	CONTRACTUAL ALLOW	279,866.81
NON-COVERD CHARGES	24,725.00	TOTAL MEDICAID LIAB	36,412.19
		LESS: COB	25.22
		LESS: COPAYMENT	1,248.00
		REIMBURSEMENT	35,138.97

TOTAL NUMBER OF CLAIMS 668

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,098.00	0.00
MED/SURG SUPPLY	9,686.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,659.00	0.00
CT SCAN	22,220.00	11,567.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,388.00	0.00
IV THERAPY	101.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	212.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	192,778.00	45.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,369.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,290.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,757.00	9,277.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,721.00	3,836.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	316,279.00	24,725.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	316,279.00	24,725.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,140.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,133.00	CONTRACTUAL ALLOW	1,550.15
NON-COVERD CHARGES	7.00	TOTAL MEDICAID LIAB	582.85
		LESS: COB	573.85
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	294.00	7.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,333.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,133.00	7.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,133.00	7.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	479,498.80	ADJUSTMENTS	65,199.22
COVERED CHARGES	474,823.80	CONTRACTUAL ALLOW	349,016.47
NON-COVERD CHARGES	4,675.00	TOTAL MEDICAID LIAB	125,807.33
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	125,684.33

TOTAL NUMBER OF CLAIMS 25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,868.00	337.00
MED/SURG SUPPLY	117,322.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	396.00	161.00
CT SCAN	5,120.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,815.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	86,806.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	722.00	0.00
ANESTHESIA	10,970.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	753.00	0.00
RECOVERY ROOM	11,560.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	208,120.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	574.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,257.00	582.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,540.00	3,595.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	474,823.80	4,675.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	474,823.80	4,675.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL
PO BOX 410
JESUP,GA 31598-0410

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,841,569.09	ADJUSTMENTS	289,052.36
COVERED CHARGES	10,608,396.29	CONTRACTUAL ALLOW	6,439,889.64
NON-COVERD CHARGES	233,172.80	TOTAL MEDICAID LIAB	4,168,506.65
		LESS: COB	45,224.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,123,281.68

TOTAL NUMBER OF ADMISSIONS 720

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,321	7	1,009,890.00	76,040.00
ROUTINE NURSERY	279	0	133,910.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,600	7	1,143,800.00	76,040.00
SPECIAL CARE SERVICES				
CCU	726	0	999,370.00	0.00
ICU	364	0	658,950.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,090	0	1,658,320.00	0.00
TOTAL ACCOMODATIONS	2,690	7	2,802,120.00	76,040.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,395,126.30	0.00
MED/SURG SUPPLY	786,890.27	3,682.15
LABORATORY-GENERAL	1,192,344.72	0.00
RADIOLOGY-DIAGNOSTIC	164,832.35	0.00
CT SCAN	389,697.40	93,193.35
PHYSICAL THERAPY	71,421.15	0.00
EKG/ECG	69,613.80	0.00
IV THERAPY	9,112.35	0.00
OPERATING ROOM	1,018,115.30	0.00
LABOR/DELIVERY ROOM	278,923.20	0.00
RESPIRATORY SERVICES	352,723.15	0.00
ANESTHESIA	292,241.75	0.00
GI SERVICES	89,247.35	0.00
EMERGENCY ROOM	655,544.50	0.00
RECOVERY ROOM	100,975.75	0.00
LABORATORY PATHOLOGIC	47,058.15	0.00
RADIOLOGY THERAPEUTIC	6,004.85	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,608.45	0.00
RENAL DIALYSIS	57,985.20	14,300.55
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,245.65
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	15,564.15	0.00
OTHER IMAGING SERVICE	70,992.15	24,161.10
BLOOD	6,836.75	0.00
BLOOD STORAGE & PRO.	155,502.15	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	47,793.65	10,540.85
AUDIOLOGY	14,716.15	0.00
CARDIOLOGY	409,999.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,178.65	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,600.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	35,760.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,068.50	0.00
OTHER THERAPEUTIC SVC	617.00	9,813.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	48,957.40	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	192.15
REHAB THERAPY	223.30	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	4.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,806,276.29	157,132.80
TOTAL ACCOMODATIONS	2,802,120.00	76,040.00
TOTAL CHARGES	10,608,396.29	233,172.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	100,847.55	ADJUSTMENTS	0.00
COVERED CHARGES	99,972.55	CONTRACTUAL ALLOW	40,904.55
NON-COVERD CHARGES	875.00	TOTAL MEDICAID LIAB	59,068.00
		LESS: COB	59,068.00
		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	19	0	14,610.00	875.00
ROUTINE NURSERY	1	0	440.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20	0	15,050.00	875.00
SPECIAL CARE SERVICES				
CCU	1	0	1,340.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	1,340.00	0.00
TOTAL ACCOMODATIONS	21	0	16,390.00	875.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,099.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,118.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,534.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	198.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,395.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	29,771.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,658.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,026.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,093.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	522.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	165.35	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	83,582.55	0.00
TOTAL ACCOMODATIONS	16,390.00	875.00
TOTAL CHARGES	99,972.55	875.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,923,936.81	ADJUSTMENTS	169,808.38
COVERED CHARGES	8,896,861.95	CONTRACTUAL ALLOW	6,939,089.80
NON-COVERD CHARGES	1,027,074.86	TOTAL MEDICAID LIAB	1,957,772.15
		LESS: COB	10,010.02
		LESS: COPAYMENT	4,447.73
		REIMBURSEMENT	1,943,314.40
		ALL OTHER	1,706,047.29
		FEE SCHEDULE-LAB	200,594.09
		INJECTABLE DRUGS	36,673.02

TOTAL NUMBER OF CLAIMS 6,011

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243,432.11	118,496.05
MED/SURG SUPPLY	300,713.69	43,826.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	286,189.75	28,946.90
CT SCAN	774,120.05	96,947.75
PHYSICAL THERAPY	10,761.90	3,308.35
EKG/ECG	81,400.95	221.70
IV THERAPY	211,552.45	12,098.00
OPERATING ROOM	1,047,379.85	159,342.55
LABOR/DELIVERY ROOM	54,346.20	0.00
RESPIRATORY SERVICES	43,651.15	5,681.15
ANESTHESIA	459,152.55	0.00
GI SERVICES	114,747.75	6,441.05
EMERGENCY ROOM	2,061,170.06	25,985.10
RECOVERY ROOM	194,319.45	580.35
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	342,575.05	3,256.25
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,284.75
RENAL DIALYSIS	0.00	5,067.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65,023.25	1,650.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	20,951.80	0.00
OTHER IMAGING SERVICE	190,943.15	28,442.15
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,459.20	9,443.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,562.40	14,359.40
AUDIOLOGY	725.80	866.50
CARDIOLOGY	174,409.90	94,924.65
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,584.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	227,290.90	2,071.72

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	151,960.10	1,364.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	445.50
OTHER THERAPEUTIC SVC	67.85	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,342,683.55	252,157.74
MRI SERVICES	70,046.85	3,988.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	327,640.04	105,522.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	355.65

TOTAL ANCILLARY	8,896,861.95	1,027,074.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,896,861.95	1,027,074.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
392	5911279001211	08/10/11 - 08/10/11	10/10/11	0.00	94.30	0.00	0.00	0.00
392	5911299000179	09/24/11 - 09/24/11	10/31/11	0.00	261.35	0.00	0.00	0.00
TOTAL				0.00	355.65	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	196,066.89	ADJUSTMENTS	0.00
COVERED CHARGES	173,526.09	CONTRACTUAL ALLOW	69,544.94
NON-COVERD CHARGES	22,540.80	TOTAL MEDICAID LIAB	103,981.15
		LESS: COB	103,972.15
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 162

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,238.35	1,320.65
MED/SURG SUPPLY	3,342.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,716.65	0.00
CT SCAN	12,503.55	4,636.45
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,272.15	0.00
IV THERAPY	5,488.90	0.00
OPERATING ROOM	17,119.25	3,333.30
LABOR/DELIVERY ROOM	17,156.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	10,988.45	0.00
GI SERVICES	0.00	1,901.45
EMERGENCY ROOM	38,283.15	86.05
RECOVERY ROOM	3,815.10	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	454.90	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,751.80	3,969.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	91.00	188.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,493.50	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/OBSERV. RM	3,764.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	38,886.44	6,863.85
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	160.00	241.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	173,526.09	22,540.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	173,526.09	22,540.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	542,792.70	ADJUSTMENTS	1,182.68
COVERED CHARGES	518,774.75	CONTRACTUAL ALLOW	468,596.57
NON-COVERD CHARGES	24,017.95	TOTAL MEDICAID LIAB	50,178.18
		LESS: COB	81.80
		LESS: COPAYMENT	1,608.08
		REIMBURSEMENT	48,488.30

TOTAL NUMBER OF CLAIMS 897

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,319.00	8,310.75
MED/SURG SUPPLY	5,404.40	291.45
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,488.00	157.15
CT SCAN	24,303.15	992.05
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,434.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,807.55	0.00
LABOR/DELIVERY ROOM	338.50	0.00
RESPIRATORY SERVICES	3,276.95	142.30
ANESTHESIA	1,918.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	340,675.55	1,358.15
RECOVERY ROOM	580.35	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,450.05	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	173.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	310.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,018.05	1,796.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	756.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,814.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	89,613.80	10,451.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,265.50	344.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	518,774.75	24,017.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	518,774.75	24,017.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,722.80	ADJUSTMENTS	0.00
COVERED CHARGES	16,181.00	CONTRACTUAL ALLOW	9,707.41
NON-COVERD CHARGES	2,541.80	TOTAL MEDICAID LIAB	6,473.59
		LESS: COB	6,461.59
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	461.50	120.25
MED/SURG SUPPLY	142.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,058.60	0.00
CT SCAN	0.00	992.05
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	110.85	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	203.55	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,205.55	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 SERVICE	1,164.35	1,041.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	694.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,108.35	246.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	141.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,181.00	2,541.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,181.00	2,541.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	496,725.01	ADJUSTMENTS	18,456.32
COVERED CHARGES	459,752.91	CONTRACTUAL ALLOW	355,001.84
NON-COVERD CHARGES	36,972.10	TOTAL MEDICAID LIAB	104,751.07
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	104,358.07

TOTAL NUMBER OF CLAIMS 22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,051.88	624.49
MED/SURG SUPPLY	32,231.21	1,603.05
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,447.90	2,175.90
CT SCAN	15,718.85	3,105.85
PHYSICAL THERAPY	0.00	284.50
EKG/ECG	1,219.35	0.00
IV THERAPY	17,006.35	1,376.80
OPERATING ROOM	55,475.55	9,544.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,455.90	198.45
ANESTHESIA	12,849.05	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,147.95	0.00
RECOVERY ROOM	5,047.95	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	161,766.85	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,924.90	192.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	916.25	1,602.45
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	35,475.10	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/OBSERV. RM	9,878.89	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	49.50
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,801.85	2,797.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	53,337.13	13,416.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	459,752.91	36,972.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	459,752.91	36,972.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,079,867.10	ADJUSTMENTS	3,171.60
COVERED CHARGES	2,008,849.10	CONTRACTUAL ALLOW	1,177,808.25
NON-COVERD CHARGES	71,018.00	TOTAL MEDICAID LIAB	831,040.85
		LESS: COB	8,511.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	822,529.68

TOTAL NUMBER OF ADMISSIONS 134

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	535	0	203,300.00	64,200.00
ROUTINE NURSERY	17	0	6,460.00	2,040.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	552	0	209,760.00	66,240.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	552	0	209,760.00	66,240.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	609,286.70	0.00
MED/SURG SUPPLY	326,181.78	0.00
LABORATORY-GENERAL	311,827.12	0.00
RADIOLOGY-DIAGNOSTIC	42,185.25	0.00
CT SCAN	162,727.50	242.00
PHYSICAL THERAPY	11,164.50	0.00
EKG/ECG	21,790.30	0.00
IV THERAPY	22,241.50	0.00
OPERATING ROOM	30,136.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	56,786.30	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,737.00	0.00
EMERGENCY ROOM	78,879.65	0.00
RECOVERY ROOM	6,734.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,064.75	0.00
SPEECH PATHOLOGY	1,274.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,829.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,872.00	0.00
BLOOD	3,585.00	0.00
BLOOD STORAGE & PRO.	24,020.50	2,706.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,213.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,349.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,856.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,963.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	18,360.75	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,852.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,799,089.10	4,778.00
TOTAL ACCOMODATIONS	209,760.00	66,240.00
TOTAL CHARGES	2,008,849.10	71,018.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,151,933.19	ADJUSTMENTS	770.26
COVERED CHARGES	3,801,840.58	CONTRACTUAL ALLOW	2,528,622.91
NON-COVERD CHARGES	350,092.61	TOTAL MEDICAID LIAB	1,273,217.67
		LESS: COB	46.69
		LESS: COPAYMENT	2,685.00
		REIMBURSEMENT	1,270,485.98
		ALL OTHER	1,215,122.26
		FEE SCHEDULE-LAB	50,505.29
		INJECTABLE DRUGS	4,858.43

TOTAL NUMBER OF CLAIMS 1,922

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	367,960.55	1,791.10
MED/SURG SUPPLY	300,536.82	0.00
LABORATORY-GENERAL	0.00	399.00
RADIOLOGY-DIAGNOSTIC	98,230.25	2,965.75
CT SCAN	151,889.00	22,534.75
PHYSICAL THERAPY	2,692.50	1,924.75
EKG/ECG	25,826.25	1,389.75
IV THERAPY	77,592.75	0.00
OPERATING ROOM	1,785,743.58	221,435.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,284.25	440.25
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	172,989.99	901.70
RECOVERY ROOM	244,496.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	982.50
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 SERVICE	9,801.50	545.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,952.00	504.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,653.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,182.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,142.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,149.64	240.21

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	67,608.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	410,199.86	91,248.50
MRI SERVICES	32,870.50	2,026.00
PROFESSIONAL FEES	0.00	431.60
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	20.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,018.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	289.75

TOTAL ANCILLARY	3,801,840.58	350,049.86
TOTAL ACCOMODATIONS	0.00	42.75
TOTAL CHARGES	3,801,840.58	350,092.61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
26	2211020005008	01/18/11 - 01/18/11	01/24/11	0.00	162.75	0.00	0.00	0.00
30	2211020005539	01/17/11 - 01/17/11	01/24/11	0.00	75.00	0.00	0.00	0.00
30	2211196014745	06/15/11 - 06/15/11	07/18/11	0.00	52.00	0.00	0.00	0.00
TOTAL				0.00	289.75	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,609.90	ADJUSTMENTS	0.00
COVERED CHARGES	2,083.40	CONTRACTUAL ALLOW	988.93
NON-COVERD CHARGES	526.50	TOTAL MEDICAID LIAB	1,094.47
		LESS: COB	1,085.53
		LESS: COPAYMENT	8.94
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	50.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,916.90	476.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,083.40	526.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,083.40	526.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,027.57	ADJUSTMENTS	105.88
COVERED CHARGES	74,246.42	CONTRACTUAL ALLOW	69,043.48
NON-COVERD CHARGES	3,781.15	TOTAL MEDICAID LIAB	5,202.94
		LESS: COB	0.00
		LESS: COPAYMENT	246.00
		REIMBURSEMENT	4,956.94

TOTAL NUMBER OF CLAIMS 98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,201.75	238.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,504.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,187.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,409.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,504.50	3,399.00
EKG/ECG	2,025.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,288.27	143.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	953.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,172.50	0.00			

TOTAL ANCILLARY	74,246.42	3,781.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,246.42	3,781.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,454.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,434.25	CONTRACTUAL ALLOW	10,121.73
NON-COVERD CHARGES	19.75	TOTAL MEDICAID LIAB	5,312.52
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	5,303.52

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,266.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	438.75	19.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	162.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,564.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	675.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	518.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,744.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,434.25	19.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,434.25	19.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN
PO BOX 398
GLENWOOD,GA 30428-0398

PROVIDER NUMBER
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	337,621.40	ADJUSTMENTS	0.00
COVERED CHARGES	334,871.40	CONTRACTUAL ALLOW	124,050.78
NON-COVERD CHARGES	2,750.00	TOTAL MEDICAID LIAB	210,820.62
		LESS: COB	1,526.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	209,294.22

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	138	0	49,030.00	650.00
ROUTINE NURSERY	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	138	0	49,030.00	650.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	72	0	70,560.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	72	0	70,560.00	0.00
TOTAL ACCOMODATIONS	210	0	119,590.00	650.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,333.40	0.00
MED/SURG SUPPLY	18,624.00	0.00
LABORATORY-GENERAL	38,659.00	0.00
RADIOLOGY-DIAGNOSTIC	3,400.00	0.00
CT SCAN	18,580.00	0.00
PHYSICAL THERAPY	1,635.00	0.00
EKG/ECG	2,135.00	0.00
IV THERAPY	2,375.00	0.00
OPERATING ROOM	1,200.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,907.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,672.00	0.00
RECOVERY ROOM	262.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	982.00	0.00
SPEECH PATHOLOGY	513.00	0.00
RENAL DIALYSIS	1,270.00	1,905.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	195.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,538.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,392.00	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/OBSERV. RM	2,528.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,258.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,530.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,300.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,008.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	215,281.40	2,100.00
TOTAL ACCOMODATIONS	119,590.00	650.00
TOTAL CHARGES	334,871.40	2,750.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	495,773.00	ADJUSTMENTS	10,420.99
COVERED CHARGES	438,705.00	CONTRACTUAL ALLOW	226,985.00
NON-COVERD CHARGES	57,068.00	TOTAL MEDICAID LIAB	211,720.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,947.00
		REIMBURSEMENT	209,773.00
		ALL OTHER	186,870.28
		FEE SCHEDULE-LAB	21,573.14
		INJECTABLE DRUGS	1,329.58

TOTAL NUMBER OF CLAIMS 1,073

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,618.00	279.00
MED/SURG SUPPLY	23,666.00	397.00
LABORATORY-GENERAL	0.00	303.00
RADIOLOGY-DIAGNOSTIC	31,137.00	279.00
CT SCAN	36,329.00	13,170.00
PHYSICAL THERAPY	7,425.00	425.00
EKG/ECG	7,705.00	320.00
IV THERAPY	10,140.00	0.00
OPERATING ROOM	29,142.00	16,111.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,338.00	75.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	57,590.00	545.00
RECOVERY ROOM	6,812.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,323.00	85.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,657.00	25.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,773.00	720.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,378.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,548.00	738.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,400.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,909.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,656.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	127,081.00	23,429.00
MRI SERVICES	25,900.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,178.00	8.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	159.00

TOTAL ANCILLARY	438,705.00	57,068.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	438,705.00	57,068.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	4010197060789	07/01/10 - 07/01/10	07/19/10	0.00	74.00	0.00	0.00	0.00
41	2211038006313	12/02/10 - 12/02/10	02/14/11	0.00	85.00	0.00	0.00	0.00
TOTAL				0.00	159.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,786.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,407.00	CONTRACTUAL ALLOW	696.79
NON-COVERD CHARGES	379.00	TOTAL MEDICAID LIAB	710.21
		LESS: COB	701.76
		LESS: COPAYMENT	8.45
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	73.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	639.00	239.00
EKG/ECG	105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	125.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	405.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	67.00			

TOTAL ANCILLARY	1,407.00	379.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,407.00	379.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,547.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,317.00	CONTRACTUAL ALLOW	8,117.00
NON-COVERD CHARGES	230.00	TOTAL MEDICAID LIAB	3,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	3,086.00

TOTAL NUMBER OF CLAIMS 64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	136.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	388.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	956.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,857.00	230.00
EKG/ECG	105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	375.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,990.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,317.00	230.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,317.00	230.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,032.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,022.00	CONTRACTUAL ALLOW	4,591.75
NON-COVERD CHARGES	10.00	TOTAL MEDICAID LIAB	4,430.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,430.25

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,260.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	956.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229.00	10.00
EKG/ECG	105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	125.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	275.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,022.00	10.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,022.00	10.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL
PO BOX 370
WASHINGTON,GA 30673-0370

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/10 THROUGH 04/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,653,904.04	ADJUSTMENTS	77,523.53
COVERED CHARGES	6,254,436.05	CONTRACTUAL ALLOW	4,357,860.71
NON-COVERD CHARGES	399,467.99	TOTAL MEDICAID LIAB	1,896,575.34
		LESS: COB	6,119.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,890,456.33

TOTAL NUMBER OF ADMISSIONS 290

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	435	382	189,209.12	297,855.52
ROUTINE NURSERY	22	0	6,679.20	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	457	382	195,888.32	297,855.52
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	248	0	263,633.92	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	248	0	263,633.92	0.00
TOTAL ACCOMODATIONS	705	382	459,522.24	297,855.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,179,537.12	0.00
MED/SURG SUPPLY	690,567.56	7,052.04
LABORATORY-GENERAL	1,090,454.32	0.00
RADIOLOGY-DIAGNOSTIC	208,170.56	713.01
CT SCAN	678,927.34	7,684.09
PHYSICAL THERAPY	48,622.55	0.00
EKG/ECG	100,201.84	0.00
IV THERAPY	1,293.47	0.00
OPERATING ROOM	311,437.53	0.00
LABOR/DELIVERY ROOM	32,940.46	0.00
RESPIRATORY SERVICES	254,160.34	0.00
ANESTHESIA	136,495.34	0.00
GI SERVICES	85,703.28	0.00
EMERGENCY ROOM	490,075.26	0.00
RECOVERY ROOM	33,887.85	0.00
LABORATORY PATHOLOGIC	6,429.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	417.67	0.00
SPEECH PATHOLOGY	8,947.03	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	104.56	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	79,085.07	2,349.24
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,820.38	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	89,423.42	13,090.70
AUDIOLOGY	435.60	0.00
CARDIOLOGY	99,634.96	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,575.84	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	38,312.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	32,445.96
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	91,243.03	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	38,277.43

TOTAL ANCILLARY	5,794,913.81	101,612.47
TOTAL ACCOMODATIONS	459,522.24	297,855.52
TOTAL CHARGES	6,254,436.05	399,467.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2011145000117	05/16/11 - 05/16/11	05/30/11	0.00	3,511.69	0.00	0.00	0.00
615	2011159029163	05/26/11 - 05/26/11	06/13/11	0.00	7,725.72	0.00	0.00	0.00
615	2011161028659	05/26/11 - 05/26/11	06/13/11	0.00	7,725.72	0.00	0.00	0.00
615	2011266009263	09/15/11 - 09/15/11	09/26/11	0.00	7,725.72	0.00	0.00	0.00
615	2011308015270	10/27/11 - 10/27/11	11/07/11	0.00	7,725.72	0.00	0.00	0.00
615	9712170955001	11/22/11 - 11/29/11	06/25/12	0.00	3,862.86	0.00	0.00	0.00
TOTAL				0.00	38,277.43	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,841.55	ADJUSTMENTS	0.00
COVERED CHARGES	13,978.29	CONTRACTUAL ALLOW	9,849.02
NON-COVERD CHARGES	863.26	TOTAL MEDICAID LIAB	4,129.27
		LESS: COB	4,129.27
		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	3	0	1,188.00	179.52
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	607.20
TOTAL ROUTINE	3	0	1,188.00	786.72
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,188.00	786.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,263.19	0.00
MED/SURG SUPPLY	1,734.16	76.54
LABORATORY-GENERAL	1,867.39	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	5,061.69	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,450.31	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	347.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	48.40	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17.16	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,790.29	76.54
TOTAL ACCOMODATIONS	1,188.00	786.72
TOTAL CHARGES	13,978.29	863.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,413,764.98	ADJUSTMENTS	869,344.21
COVERED CHARGES	9,531,462.42	CONTRACTUAL ALLOW	7,508,238.66
NON-COVERD CHARGES	882,302.56	TOTAL MEDICAID LIAB	2,023,223.76
		LESS: COB	4,173.94
		LESS: COPAYMENT	3,132.00
		REIMBURSEMENT	2,015,917.82
		ALL OTHER	1,906,273.79
		FEE SCHEDULE-LAB	100,526.56
		INJECTABLE DRUGS	9,117.47

TOTAL NUMBER OF CLAIMS 3,074

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,783.40	52,082.70
MED/SURG SUPPLY	247,048.73	17,591.35
LABORATORY-GENERAL	0.00	14.61
RADIOLOGY-DIAGNOSTIC	620,178.21	13,843.25
CT SCAN	1,581,064.26	193,950.17
PHYSICAL THERAPY	14,380.96	5,991.82
EKG/ECG	114,754.74	0.00
IV THERAPY	7,321.03	0.00
OPERATING ROOM	525,436.31	160,257.74
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,769.67	648.90
ANESTHESIA	406,430.72	7,592.87
GI SERVICES	391,774.62	46,254.48
EMERGENCY ROOM	3,114,647.45	728.49
RECOVERY ROOM	159,811.17	111.83
LABORATORY PATHOLOGIC	0.00	225.01
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	418.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,180.29
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	257,011.17	7,805.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	121,768.90	13,868.64
AUDIOLOGY	0.00	0.00
CARDIOLOGY	43,454.97	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/OBSERV. RM	83,267.53	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	79,279.98	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	8,842.54
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,023,982.54	203,961.96
MRI SERVICES	478,158.97	11,237.41
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	224,719.09	135,113.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,531,462.42	882,302.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,531,462.42	882,302.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,302.59	ADJUSTMENTS	0.00
COVERED CHARGES	86,953.60	CONTRACTUAL ALLOW	24,946.37
NON-COVERD CHARGES	31,348.99	TOTAL MEDICAID LIAB	62,007.23
		LESS: COB	61,995.50
		LESS: COPAYMENT	11.73
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	573.01	41.45	OTHER LAB	0.00	1,361.91
MED/SURG SUPPLY	3,157.37	844.94	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,741.35	502.25	OTHER THERAPEUTIC SVC	0.00	731.18
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,539.38	1,753.08
EKG/ECG	964.32	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	18,390.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,853.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,829.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,156.93	1.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,940.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.25	7,722.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,345.06	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/OBSERV. RM	2,713.06	0.00			

TOTAL ANCILLARY	86,953.60	31,348.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,953.60	31,348.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,024,141.56	ADJUSTMENTS	3,049.79
COVERED CHARGES	995,583.90	CONTRACTUAL ALLOW	967,082.26
NON-COVERD CHARGES	28,557.66	TOTAL MEDICAID LIAB	28,501.64
		LESS: COB	0.00
		LESS: COPAYMENT	942.06
		REIMBURSEMENT	27,559.58

TOTAL NUMBER OF CLAIMS 510

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33.97	8,471.02
MED/SURG SUPPLY	9,050.18	4.30
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,159.48	0.00
CT SCAN	69,597.27	3,300.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,870.54	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,418.07	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,908.09	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	749,902.87	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 SERVICE	3,617.13	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	591.21	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,075.29	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	83,905.07	11,470.61
MRI SERVICES	4,269.49	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,185.24	5,311.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	995,583.90	28,557.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	995,583.90	28,557.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,730.85	ADJUSTMENTS	0.00
COVERED CHARGES	17,212.14	CONTRACTUAL ALLOW	10,796.69
NON-COVERD CHARGES	518.71	TOTAL MEDICAID LIAB	6,415.45
		LESS: COB	6,403.45
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	430.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,289.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,007.59	14.61
EKG/ECG	292.22	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	438.62	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,704.51	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	504.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,212.14	518.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,212.14	518.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	360,330.42	ADJUSTMENTS	55,106.20
COVERED CHARGES	342,160.88	CONTRACTUAL ALLOW	277,175.82
NON-COVERD CHARGES	18,169.54	TOTAL MEDICAID LIAB	64,985.06
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	64,937.06

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	294.19
MED/SURG SUPPLY	120,117.35	2,278.16
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,672.52	0.00
CT SCAN	0.00	2,209.88
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	613.66	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	108,735.77	4,676.19
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	231.64	0.00
ANESTHESIA	50,606.64	0.00
GI SERVICES	12,013.70	0.00
EMERGENCY ROOM	3,725.60	0.00
RECOVERY ROOM	20,132.23	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,569.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,139.45	915.66
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,602.88	7,795.46
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	342,160.88	18,169.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,160.88	18,169.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
PO BOX 688
WINDER,GA 30680-0688

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	302,163.00	ADJUSTMENTS	2,333.25
COVERED CHARGES	295,739.00	CONTRACTUAL ALLOW	121,537.10
NON-COVERD CHARGES	6,424.00	TOTAL MEDICAID LIAB	174,201.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	174,201.90

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	128	0	57,618.00	6,424.00
ROUTINE NURSERY	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	128	0	57,618.00	6,424.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	128	0	57,618.00	6,424.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,680.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55,816.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,587.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,802.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,958.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,434.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,690.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,722.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,026.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	763.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	657.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	997.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,621.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,368.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	238,121.00	0.00
TOTAL ACCOMODATIONS	57,618.00	6,424.00
TOTAL CHARGES	295,739.00	6,424.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,018,341.00	ADJUSTMENTS	11,258.97
COVERED CHARGES	946,670.00	CONTRACTUAL ALLOW	621,056.25
NON-COVERD CHARGES	71,671.00	TOTAL MEDICAID LIAB	325,613.75
		LESS: COB	243.43
		LESS: COPAYMENT	816.00
		REIMBURSEMENT	324,554.32
		ALL OTHER	296,495.74
		FEE SCHEDULE-LAB	23,475.31
		INJECTABLE DRUGS	4,583.27

TOTAL NUMBER OF CLAIMS 1,151

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,680.00	10.00
MED/SURG SUPPLY	51,086.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,111.00	935.00
CT SCAN	112,741.00	8,527.00
PHYSICAL THERAPY	1,218.00	95.00
EKG/ECG	14,965.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,091.00	0.00
ANESTHESIA	1,380.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	318,320.00	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 SERVICE	27,622.00	1,294.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	15,149.00	1,495.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,472.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,872.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,334.00	3,399.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,536.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	230,202.00	47,643.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,891.00	7,044.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	946,670.00	71,671.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	946,670.00	71,671.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,410.00	ADJUSTMENTS	0.00
COVERED CHARGES	22,411.00	CONTRACTUAL ALLOW	2,165.34
NON-COVERD CHARGES	7,999.00	TOTAL MEDICAID LIAB	20,245.66
		LESS: COB	20,236.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	554.00	0.00
MED/SURG SUPPLY	1,564.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,983.00	0.00
CT SCAN	3,942.00	6,730.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	615.00	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	184.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,250.00	41.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,032.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,287.00	1,228.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,411.00	7,999.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,411.00	7,999.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	123,140.00	ADJUSTMENTS	144.00
COVERED CHARGES	119,827.00	CONTRACTUAL ALLOW	108,877.00
NON-COVERD CHARGES	3,313.00	TOTAL MEDICAID LIAB	10,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	402.00
		REIMBURSEMENT	10,548.00

TOTAL NUMBER OF CLAIMS 219

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,093.00	56.00
MED/SURG SUPPLY	4,639.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,466.00	0.00
CT SCAN	1,346.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,435.00	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	88,410.00	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 SERVICE	3,430.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	692.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,454.00	1,792.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,862.00	1,465.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	119,827.00	3,313.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,827.00	3,313.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,789.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,789.00	CONTRACTUAL ALLOW	791.65
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	997.35
		LESS: COB	997.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	84.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,660.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,789.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,789.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/10 THROUGH 07/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,321,180.53	ADJUSTMENTS	34,324.66
COVERED CHARGES	6,231,038.35	CONTRACTUAL ALLOW	3,933,585.87
NON-COVERD CHARGES	90,142.18	TOTAL MEDICAID LIAB	2,297,452.48
		LESS: COB	21,717.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,275,735.07

TOTAL NUMBER OF ADMISSIONS 364

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	616	39	276,731.10	17,901.00
ROUTINE NURSERY	83	0	21,912.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	699	39	298,643.10	17,901.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	540	0	527,038.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	540	0	527,038.00	0.00
TOTAL ACCOMODATIONS	1,239	39	825,681.10	17,901.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	916,313.93	0.00
MED/SURG SUPPLY	214,573.66	413.24
LABORATORY-GENERAL	1,211,423.20	0.00
RADIOLOGY-DIAGNOSTIC	182,949.44	12,410.39
CT SCAN	508,423.09	0.00
PHYSICAL THERAPY	51,189.41	0.00
EKG/ECG	103,190.90	0.00
IV THERAPY	14,623.74	0.00
OPERATING ROOM	295,577.35	0.00
LABOR/DELIVERY ROOM	44,939.44	0.00
RESPIRATORY SERVICES	147,633.14	0.00
ANESTHESIA	290,304.06	0.00
GI SERVICES	58,416.08	0.00
EMERGENCY ROOM	483,694.84	0.00
RECOVERY ROOM	92,128.97	0.00
LABORATORY PATHOLOGIC	12,368.89	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	8,189.84	0.00
SPEECH PATHOLOGY	19,855.66	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	27.16	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	75,734.99	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	49,689.55	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	84,327.10	8,037.46
AUDIOLOGY	385.24	4,685.60
CARDIOLOGY	320,105.07	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,170.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,550.23	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	110,398.71	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	346.05
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	96,333.82	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,839.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	46,348.44

TOTAL ANCILLARY	5,405,357.25	72,241.18
TOTAL ACCOMODATIONS	825,681.10	17,901.00
TOTAL CHARGES	6,231,038.35	90,142.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2010323046526	10/29/10 - 11/01/10	11/22/10	0.00	3,400.34	0.00	0.00	0.00
615	2010343006620	11/30/10 - 12/02/10	12/13/10	0.00	3,400.34	0.00	0.00	0.00
615	2010362017247	12/19/10 - 12/20/10	01/03/11	0.00	3,400.34	0.00	0.00	0.00
615	2011053021246	01/17/11 - 01/17/11	02/28/11	0.00	2,943.06	0.00	0.00	0.00
615	2011053021131	01/20/11 - 01/20/11	02/28/11	0.00	3,570.36	0.00	0.00	0.00
615	2011122009379	02/03/11 - 02/03/11	05/09/11	0.00	3,570.36	0.00	0.00	0.00
615	2011161028765	05/23/11 - 05/23/11	06/13/11	0.00	3,927.40	0.00	0.00	0.00
615	2011224032719	08/04/11 - 08/04/11	08/15/11	0.00	3,927.40	0.00	0.00	0.00
615	2011280008553	08/01/11 - 08/01/11	10/10/11	0.00	3,927.40	0.00	0.00	0.00
615	2011291028125	05/04/11 - 05/04/11	10/24/11	0.00	3,570.36	0.00	0.00	0.00
615	9111312000073	03/14/11 - 03/14/11	11/14/11	0.00	3,570.36	0.00	2,010.52	0.00
615	2012083062542	05/14/11 - 05/15/11	03/26/12	0.00	3,570.36	0.00	0.00	0.00
615	2012207018644	04/07/11 - 04/15/11	07/30/12	0.00	3,570.36	0.00	0.00	0.00
TOTAL				0.00	46,348.44	0.00	2,010.52	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,946,071.10	ADJUSTMENTS	170,337.65
COVERED CHARGES	6,044,622.07	CONTRACTUAL ALLOW	4,812,443.52
NON-COVERD CHARGES	901,449.03	TOTAL MEDICAID LIAB	1,232,178.55
		LESS: COB	1,000.01
		LESS: COPAYMENT	2,522.60
		REIMBURSEMENT	1,228,655.94
		ALL OTHER	1,130,624.23
		FEE SCHEDULE-LAB	89,761.95
		INJECTABLE DRUGS	8,269.76

TOTAL NUMBER OF CLAIMS 3,058

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,187.44	76,871.65
MED/SURG SUPPLY	131,948.83	30,382.92
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	323,799.22	18,747.60
CT SCAN	753,487.60	302,448.67
PHYSICAL THERAPY	0.00	953.41
EKG/ECG	92,447.44	0.00
IV THERAPY	36,376.66	0.00
OPERATING ROOM	191,522.35	94,839.47
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,796.81	2,973.81
ANESTHESIA	263,692.61	5,030.27
GI SERVICES	110,375.25	47,812.90
EMERGENCY ROOM	2,159,043.86	3,435.74
RECOVERY ROOM	224,299.99	3,745.37
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	712.59
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	251,940.59	13,137.62
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,507.71	1,452.89
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	92,726.76	8,293.81
AUDIOLOGY	0.00	0.00
CARDIOLOGY	87,264.50	5,833.05
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/OBSERV. RM	74,154.77	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	140,806.74	1,804.88
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	177.60	0.00
OTHER THERAPEUTIC SVC	0.00	14,332.39
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	822,997.25	142,035.83
MRI SERVICES	90,166.73	3,483.55
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	153,901.36	123,120.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,044,622.07	901,449.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,044,622.07	901,449.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,349.10	ADJUSTMENTS	0.00
COVERED CHARGES	33,154.75	CONTRACTUAL ALLOW	12,286.37
NON-COVERD CHARGES	16,194.35	TOTAL MEDICAID LIAB	20,868.38
		LESS: COB	20,862.38
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215.39	0.00
MED/SURG SUPPLY	1,778.86	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	727.46	0.00
CT SCAN	4,388.88	5,112.13
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	7,892.99
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,610.13	560.58
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,220.95	1,175.01
RECOVERY ROOM	2,290.86	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,282.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,367.88	5.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	271.84	1,448.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,154.75	16,194.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,154.75	16,194.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	619,925.10	ADJUSTMENTS	788.05
COVERED CHARGES	557,165.17	CONTRACTUAL ALLOW	527,672.11
NON-COVERD CHARGES	62,759.93	TOTAL MEDICAID LIAB	29,493.06
		LESS: COB	0.00
		LESS: COPAYMENT	978.06
		REIMBURSEMENT	28,515.00

TOTAL NUMBER OF CLAIMS 527

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,482.60	5,739.62	OTHER LAB	1,804.88	6,253.89
MED/SURG SUPPLY	2,494.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,605.86	0.00	OTHER THERAPEUTIC SVC	0.00	303.02
CT SCAN	27,378.98	28,949.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	81,894.71	12,868.94
EKG/ECG	9,426.21	0.00	MRI SERVICES	3,400.34	3,317.67
IV THERAPY	3,517.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,572.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	374,391.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,757.80	3,832.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	23.51	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,835.88	1,471.65			
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	4,261.31	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,340.65	0.00			

TOTAL ANCILLARY	557,165.17	62,759.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	557,165.17	62,759.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	315.07	ADJUSTMENTS	0.00
COVERED CHARGES	315.07	CONTRACTUAL ALLOW	187.98
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	127.09
		LESS: COB	127.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	315.07	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	315.07	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	307,084.33	ADJUSTMENTS	0.00
COVERED CHARGES	276,046.53	CONTRACTUAL ALLOW	227,844.08
NON-COVERD CHARGES	31,037.80	TOTAL MEDICAID LIAB	48,202.45
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	48,160.45

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,068.98
MED/SURG SUPPLY	32,738.39	320.95
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,862.29	406.17
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	320.67	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	82,476.74	22,537.93
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	72,039.33	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,514.75	0.00
RECOVERY ROOM	21,688.12	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	26,805.52	0.00
OTHER IMAGING SERVICE	969.14	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,675.61	636.57
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,464.40	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/OBSERV. RM	4,434.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,251.21	1,119.54
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,806.36	4,947.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	276,046.53	31,037.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	276,046.53	31,037.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
PO BOX 1346
MONROE,GA 30655-1346

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/10 THROUGH 09/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,221,098.77	ADJUSTMENTS	93,817.22
COVERED CHARGES	2,197,010.77	CONTRACTUAL ALLOW	1,450,785.44
NON-COVERD CHARGES	24,088.00	TOTAL MEDICAID LIAB	746,225.33
		LESS: COB	3,672.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	742,553.29

TOTAL NUMBER OF ADMISSIONS 111

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	312	7	207,480.00	12,113.00
ROUTINE NURSERY	15	0	9,975.00	3,648.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	327	7	217,455.00	15,761.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	95	1	106,020.00	1,290.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	95	1	106,020.00	1,290.00
TOTAL ACCOMODATIONS	422	8	323,475.00	17,051.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	649,520.73	2,854.00
MED/SURG SUPPLY	165,023.48	0.00
LABORATORY-GENERAL	338,184.00	0.00
RADIOLOGY-DIAGNOSTIC	32,749.00	0.00
CT SCAN	156,559.00	0.00
PHYSICAL THERAPY	15,048.56	0.00
EKG/ECG	16,038.00	0.00
IV THERAPY	2,706.00	0.00
OPERATING ROOM	73,773.00	0.00
LABOR/DELIVERY ROOM	18,372.00	0.00
RESPIRATORY SERVICES	122,492.00	0.00
ANESTHESIA	36,584.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	123,740.00	0.00
RECOVERY ROOM	4,875.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,583.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,243.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,796.00	2,062.00
AUDIOLOGY	1,655.00	0.00
CARDIOLOGY	29,740.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,978.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,948.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,121.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,240.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,688.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,873,535.77	7,037.00
TOTAL ACCOMODATIONS	323,475.00	17,051.00
TOTAL CHARGES	2,197,010.77	24,088.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,331,096.28	ADJUSTMENTS	92,805.27
COVERED CHARGES	1,900,046.61	CONTRACTUAL ALLOW	1,514,615.29
NON-COVERD CHARGES	431,049.67	TOTAL MEDICAID LIAB	385,431.32
		LESS: COB	2,211.29
		LESS: COPAYMENT	1,362.00
		REIMBURSEMENT	381,858.03
		ALL OTHER	349,454.58
		FEE SCHEDULE-LAB	32,386.38
		INJECTABLE DRUGS	17.07
		TOTAL NUMBER OF CLAIMS	1,238

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,460.75	91,350.00
MED/SURG SUPPLY	152,958.75	2,720.92
LABORATORY-GENERAL	0.00	2,310.00
RADIOLOGY-DIAGNOSTIC	107,808.00	1,863.00
CT SCAN	204,060.00	65,059.00
PHYSICAL THERAPY	1,597.36	982.00
EKG/ECG	20,333.00	0.00
IV THERAPY	30,706.00	277.00
OPERATING ROOM	116,213.25	131,329.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,094.00	1,317.00
ANESTHESIA	121,151.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	378,691.00	6,388.00
RECOVERY ROOM	14,904.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,438.00	2,352.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	94,610.00	4,750.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	387.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,454.00	8,785.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,544.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	44,296.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,278.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,069.00	862.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	6,511.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	399,782.00	81,998.00
MRI SERVICES	24,955.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,256.00	20,047.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	18.00

TOTAL ANCILLARY	1,900,046.61	428,919.67
TOTAL ACCOMODATIONS	0.00	2,130.00
TOTAL CHARGES	1,900,046.61	431,049.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2211231020158	02/01/11 - 02/01/11	08/29/11	0.00	18.00	0.00	0.00	0.00
TOTAL				0.00	18.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,424.00	ADJUSTMENTS	0.00
COVERED CHARGES	46,939.00	CONTRACTUAL ALLOW	17,964.39
NON-COVERD CHARGES	9,485.00	TOTAL MEDICAID LIAB	28,974.61
		LESS: COB	28,854.61
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,520.00	0.00
MED/SURG SUPPLY	1,470.00	0.00
LABORATORY-GENERAL	0.00	3,269.00
RADIOLOGY-DIAGNOSTIC	1,379.00	0.00
CT SCAN	3,529.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,623.00	0.00
OPERATING ROOM	1,878.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,067.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,277.00	421.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	10,442.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,639.00	3,119.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,348.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	525.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,242.00	546.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	46,939.00	7,355.00
TOTAL ACCOMODATIONS	0.00	2,130.00
TOTAL CHARGES	46,939.00	9,485.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,412.50	ADJUSTMENTS	1,079.80
COVERED CHARGES	83,654.50	CONTRACTUAL ALLOW	78,728.34
NON-COVERD CHARGES	9,758.00	TOTAL MEDICAID LIAB	4,926.16
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	4,797.16

TOTAL NUMBER OF CLAIMS 90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,136.50	4,170.00	OTHER LAB	1,050.00	0.00
MED/SURG SUPPLY	3,477.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,482.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,938.00	4,833.00
EKG/ECG	1,584.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	824.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	378.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,226.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	755.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,601.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,808.00	0.00			

TOTAL ANCILLARY	83,654.50	9,758.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,654.50	9,758.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,132.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,938.00	CONTRACTUAL ALLOW	1,700.41
NON-COVERD CHARGES	1,194.00	TOTAL MEDICAID LIAB	237.59
		LESS: COB	237.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	678.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	625.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	635.00	1,194.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,938.00	1,194.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,938.00	1,194.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	107,594.38	ADJUSTMENTS	4,959.36
COVERED CHARGES	106,383.38	CONTRACTUAL ALLOW	96,449.65
NON-COVERD CHARGES	1,211.00	TOTAL MEDICAID LIAB	9,933.73
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,927.73

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,089.00	33.00
MED/SURG SUPPLY	22,180.38	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	748.00	1,178.00
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	3,849.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	74.00	0.00
ANESTHESIA	1,616.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	76,500.00	0.00
RECOVERY ROOM	184.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	143.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	106,383.38	1,211.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	106,383.38	1,211.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,959,759.05	ADJUSTMENTS	56,336.30
COVERED CHARGES	3,844,401.85	CONTRACTUAL ALLOW	3,033,348.49
NON-COVERD CHARGES	115,357.20	TOTAL MEDICAID LIAB	811,053.36
		LESS: COB	15,255.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	795,797.75

TOTAL NUMBER OF ADMISSIONS 272

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	290	136	182,501.00	109,627.60
ROUTINE NURSERY	224	0	114,751.63	5,385.20
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	514	136	297,252.63	115,012.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	60	0	60,234.36	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	60	0	60,234.36	0.00
TOTAL ACCOMODATIONS	574	136	357,486.99	115,012.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	733,145.72	0.00
MED/SURG SUPPLY	133,016.09	0.00
LABORATORY-GENERAL	626,896.35	0.00
RADIOLOGY-DIAGNOSTIC	32,141.51	0.00
CT SCAN	116,945.05	0.00
PHYSICAL THERAPY	8,614.20	0.00
EKG/ECG	12,342.32	0.00
IV THERAPY	179.55	0.00
OPERATING ROOM	220,498.02	0.00
LABOR/DELIVERY ROOM	418,148.31	0.00
RESPIRATORY SERVICES	100,968.67	0.00
ANESTHESIA	33,014.10	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	98,183.05	0.00
RECOVERY ROOM	20,254.85	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	511.35	0.00
SPEECH PATHOLOGY	2,743.65	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,260.78	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,577.30	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,907.70	344.40
AUDIOLOGY	13,168.00	0.00
CARDIOLOGY	14,373.15	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,362.11	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,299.73	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	857,363.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,486,914.86	344.40
TOTAL ACCOMODATIONS	357,486.99	115,012.80
TOTAL CHARGES	3,844,401.85	115,357.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,704.95	ADJUSTMENTS	0.00
COVERED CHARGES	86,412.95	CONTRACTUAL ALLOW	38,100.21
NON-COVERD CHARGES	292.00	TOTAL MEDICAID LIAB	48,312.74
		LESS: COB	48,312.74
		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	5	0	3,131.00	292.00
ROUTINE NURSERY	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	3,131.00	292.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	3,131.00	292.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,809.70	0.00
MED/SURG SUPPLY	121.80	0.00
LABORATORY-GENERAL	8,951.25	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	36,776.25	0.00
LABOR/DELIVERY ROOM	4,568.55	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,252.10	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,563.45	0.00
RECOVERY ROOM	3,893.95	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,295.70	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/OBSERV. RM	594.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,454.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	83,281.95	0.00
TOTAL ACCOMODATIONS	3,131.00	292.00
TOTAL CHARGES	86,412.95	292.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,502,412.47	ADJUSTMENTS	173,920.61
COVERED CHARGES	3,039,210.58	CONTRACTUAL ALLOW	2,512,480.19
NON-COVERD CHARGES	463,201.89	TOTAL MEDICAID LIAB	526,730.39
		LESS: COB	3,079.06
		LESS: COPAYMENT	1,701.31
		REIMBURSEMENT	521,950.02
		ALL OTHER	475,285.61
		FEE SCHEDULE-LAB	36,247.37
		INJECTABLE DRUGS	10,417.04

TOTAL NUMBER OF CLAIMS 1,281

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141,070.89	65,473.12
MED/SURG SUPPLY	19,046.29	5,900.40
LABORATORY-GENERAL	0.00	7,755.53
RADIOLOGY-DIAGNOSTIC	114,845.82	6,731.28
CT SCAN	288,585.09	23,199.10
PHYSICAL THERAPY	19,829.97	7,876.83
EKG/ECG	37,336.96	0.00
IV THERAPY	10,204.55	0.00
OPERATING ROOM	375,648.50	103,534.67
LABOR/DELIVERY ROOM	0.00	707.70
RESPIRATORY SERVICES	19,819.59	0.00
ANESTHESIA	81,406.46	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	481,638.30	10,856.84
RECOVERY ROOM	78,766.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	493.50
SPEECH PATHOLOGY	392.70	404.25
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25,422.40	557.24
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	81,341.41	6,887.54
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,574.95	3,715.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	66,619.34	6,588.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	58,712.74	1,400.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,994.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	35,707.39	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	148,066.10	2,846.52
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,444.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	687,118.71	138,235.81
MRI SERVICES	61,846.02	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	193,215.40	66,593.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,039,210.58	463,201.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,039,210.58	463,201.89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	111,726.81	ADJUSTMENTS	0.00
COVERED CHARGES	87,301.68	CONTRACTUAL ALLOW	38,006.29
NON-COVERD CHARGES	24,425.13	TOTAL MEDICAID LIAB	49,295.39
		LESS: COB	49,265.39
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,827.16	2,593.90
MED/SURG SUPPLY	62.42	1,152.90
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,236.19	0.00
CT SCAN	2,169.30	5,654.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,607.66	0.00
IV THERAPY	1,770.00	0.00
OPERATING ROOM	7,248.98	9,851.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,972.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,759.41	0.00
RECOVERY ROOM	2,540.64	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	719.09	1,633.33
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,741.55	662.55
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	193.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,823.58	2,877.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	630.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	87,301.68	24,425.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,301.68	24,425.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	230,713.96	ADJUSTMENTS	1,270.55
COVERED CHARGES	212,120.90	CONTRACTUAL ALLOW	202,611.10
NON-COVERD CHARGES	18,593.06	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	357.01
		REIMBURSEMENT	9,152.79

TOTAL NUMBER OF CLAIMS 170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,554.45	6,088.88	OTHER LAB	603.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,169.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,680.89	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58,489.57	9,518.14
EKG/ECG	3,517.77	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,550.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,472.68	297.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,702.85	2,287.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	5,021.12	401.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,658.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,701.00	0.00			

TOTAL ANCILLARY	212,120.90	18,593.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	212,120.90	18,593.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,085.82	ADJUSTMENTS	0.00
COVERED CHARGES	11,021.37	CONTRACTUAL ALLOW	10,540.37
NON-COVERD CHARGES	1,064.45	TOTAL MEDICAID LIAB	481.00
		LESS: COB	475.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180.82	173.20
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	194.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	251.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	775.00	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	2,695.90	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,924.65	891.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,021.37	1,064.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,021.37	1,064.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	400,042.31	ADJUSTMENTS	47,777.77
COVERED CHARGES	345,283.73	CONTRACTUAL ALLOW	287,311.90
NON-COVERD CHARGES	54,758.58	TOTAL MEDICAID LIAB	57,971.83
		LESS: COB	4,120.12
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	53,698.71

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,588.19	4,219.90
MED/SURG SUPPLY	5,583.10	12,921.30
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	401.31	737.31
CT SCAN	6,281.94	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	15,149.40	0.00
OPERATING ROOM	169,791.60	6,079.29
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	825.30	0.00
ANESTHESIA	28,674.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,249.03	0.00
RECOVERY ROOM	18,268.72	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,935.80	143.85
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,754.19	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,138.94	2,524.21
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	41,642.06	28,132.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	345,283.73	54,758.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	345,283.73	54,758.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,214,002.21	ADJUSTMENTS	461,873.15
COVERED CHARGES	11,009,363.84	CONTRACTUAL ALLOW	8,213,436.92
NON-COVERD CHARGES	204,638.37	TOTAL MEDICAID LIAB	2,795,926.92
		LESS: COB	19,358.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,776,567.94

TOTAL NUMBER OF ADMISSIONS 450

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,308	0	519,276.00	138,285.00
ROUTINE NURSERY	114	0	44,579.00	1,871.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	1,422	3	563,855.00	140,156.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	553	6	481,930.00	6,930.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	553	6	481,930.00	6,930.00
TOTAL ACCOMODATIONS	1,975	9	1,045,785.00	147,086.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,349,073.40	0.00
MED/SURG SUPPLY	938,723.50	0.00
LABORATORY-GENERAL	1,975,233.53	0.00
RADIOLOGY-DIAGNOSTIC	201,612.00	0.00
CT SCAN	460,310.00	2,303.00
PHYSICAL THERAPY	65,357.00	0.00
EKG/ECG	57,456.00	0.00
IV THERAPY	87,196.00	0.00
OPERATING ROOM	712,144.37	0.00
LABOR/DELIVERY ROOM	188,161.00	0.00
RESPIRATORY SERVICES	395,021.00	0.00
ANESTHESIA	128,718.00	0.00
GI SERVICES	96,449.56	0.00
EMERGENCY ROOM	478,406.00	0.00
RECOVERY ROOM	61,780.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	23,969.95	0.00
OCCUPATIONAL THERAPY	11,542.00	0.00
SPEECH PATHOLOGY	3,481.00	0.00
RENAL DIALYSIS	43,455.00	50,140.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	311.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,292.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	120,624.00	1,013.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,206.00	1,902.00
AUDIOLOGY	11,500.00	84.57
CARDIOLOGY	151,333.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,918.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,778.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	50,446.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	124.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	112,320.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,113,072.28	1,674.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,963,578.84	57,552.37
TOTAL ACCOMODATIONS	1,045,785.00	147,086.00
TOTAL CHARGES	11,009,363.84	204,638.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,132.65	ADJUSTMENTS	0.00
COVERED CHARGES	66,998.65	CONTRACTUAL ALLOW	37,615.96
NON-COVERD CHARGES	1,134.00	TOTAL MEDICAID LIAB	29,382.69
		LESS: COB	29,382.69
		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	18	0	7,146.00	1,134.00
ROUTINE NURSERY	2	0	714.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20	0	7,860.00	1,134.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	20	0	7,860.00	1,134.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,991.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,069.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,122.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	356.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,344.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,802.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,690.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,100.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,083.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,142.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	250.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	59,138.65	0.00
TOTAL ACCOMODATIONS	7,860.00	1,134.00
TOTAL CHARGES	66,998.65	1,134.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,484,344.51	ADJUSTMENTS	276,916.48
COVERED CHARGES	6,496,077.85	CONTRACTUAL ALLOW	5,276,591.93
NON-COVERD CHARGES	988,266.66	TOTAL MEDICAID LIAB	1,219,485.92
		LESS: COB	14,275.39
		LESS: COPAYMENT	1,156.12
		REIMBURSEMENT	1,204,054.41
		ALL OTHER	1,075,986.45
		FEE SCHEDULE-LAB	107,125.79
		INJECTABLE DRUGS	20,942.17

TOTAL NUMBER OF CLAIMS 2,514

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,779.60	2,649.00
MED/SURG SUPPLY	411,075.10	8,055.10
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	400,038.00	1,437.00
CT SCAN	569,881.00	70,688.00
PHYSICAL THERAPY	0.00	786.00
EKG/ECG	69,552.00	0.00
IV THERAPY	230,012.00	0.00
OPERATING ROOM	617,753.51	342,450.16
LABOR/DELIVERY ROOM	31,170.00	13,668.00
RESPIRATORY SERVICES	50,175.00	0.00
ANESTHESIA	186,876.00	3,396.00
GI SERVICES	24,158.50	2,731.50
EMERGENCY ROOM	1,475,091.50	113,100.00
RECOVERY ROOM	119,107.00	4,710.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	572.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	364.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,866.00	13,684.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	72,448.00	5,993.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,414.00	1,013.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,293.00	12,308.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,173.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	313,776.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	26,116.00	3,677.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,795.00	1,674.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	510.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,446,085.64	273,768.40
MRI SERVICES	10,474.00	3,456.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	174,396.00	108,125.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,496,077.85	988,243.66
TOTAL ACCOMODATIONS	0.00	23.00
TOTAL CHARGES	6,496,077.85	988,266.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	123,658.29	ADJUSTMENTS	0.00
COVERED CHARGES	95,147.82	CONTRACTUAL ALLOW	49,875.85
NON-COVERD CHARGES	28,510.47	TOTAL MEDICAID LIAB	45,271.97
		LESS: COB	45,259.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,198.21	0.00
MED/SURG SUPPLY	7,016.08	0.00
LABORATORY-GENERAL	0.00	282.00
RADIOLOGY-DIAGNOSTIC	3,472.00	0.00
CT SCAN	8,900.00	1,805.00
PHYSICAL THERAPY	0.00	222.00
EKG/ECG	567.00	0.00
IV THERAPY	3,033.00	0.00
OPERATING ROOM	9,438.00	15,702.72
LABOR/DELIVERY ROOM	566.00	1,456.00
RESPIRATORY SERVICES	981.00	0.00
ANESTHESIA	2,502.00	0.00
GI SERVICES	0.00	1,340.00
EMERGENCY ROOM	23,913.00	659.00
RECOVERY ROOM	1,607.71	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	364.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,758.00	795.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	260.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	970.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,564.00	2,959.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	401.82	2,925.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	95,147.82	28,510.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	95,147.82	28,510.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	835,659.85	ADJUSTMENTS	7,681.42
COVERED CHARGES	762,183.85	CONTRACTUAL ALLOW	732,184.64
NON-COVERD CHARGES	73,476.00	TOTAL MEDICAID LIAB	29,999.21
		LESS: COB	0.00
		LESS: COPAYMENT	1,191.06
		REIMBURSEMENT	28,808.15

TOTAL NUMBER OF CLAIMS 538

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,808.10	69.00
MED/SURG SUPPLY	18,572.85	266.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,891.00	599.00
CT SCAN	38,579.00	5,826.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,048.00	0.00
IV THERAPY	25,272.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,503.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	336,695.90	10,296.00
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 SERVICE	14,014.00	786.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	599.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	624.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,497.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	221,832.00	48,771.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,847.00	6,264.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	762,183.85	73,476.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	762,183.85	73,476.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,375.70	ADJUSTMENTS	0.00
COVERED CHARGES	13,136.70	CONTRACTUAL ALLOW	8,510.74
NON-COVERD CHARGES	9,239.00	TOTAL MEDICAID LIAB	4,625.96
		LESS: COB	4,611.05
		LESS: COPAYMENT	14.91
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	439.00	0.00
MED/SURG SUPPLY	509.70	0.00
LABORATORY-GENERAL	0.00	34.00
RADIOLOGY-DIAGNOSTIC	1,383.00	0.00
CT SCAN	0.00	4,021.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	189.00	0.00
IV THERAPY	202.00	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	5,940.00	4,690.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,952.00	494.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	51.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,136.70	9,239.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,136.70	9,239.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	665,616.34	ADJUSTMENTS	19,997.44
COVERED CHARGES	613,647.51	CONTRACTUAL ALLOW	509,624.11
NON-COVERD CHARGES	51,968.83	TOTAL MEDICAID LIAB	104,023.40
		LESS: COB	3,142.93
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	100,787.47

TOTAL NUMBER OF CLAIMS 21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,907.05	0.00
MED/SURG SUPPLY	127,065.05	7,754.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,624.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	672.00
EKG/ECG	2,456.25	0.00
IV THERAPY	942.00	0.00
OPERATING ROOM	268,080.33	34,739.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	278.00	0.00
ANESTHESIA	57,612.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,122.00	0.00
RECOVERY ROOM	26,710.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	56,030.00	0.00
OTHER IMAGING SERVICE	2,514.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,157.00	4,273.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,042.83	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,397.25	1,387.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	709.75	3,142.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	613,647.51	51,968.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	613,647.51	51,968.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	920,376.18	ADJUSTMENTS	16,103.36
COVERED CHARGES	918,856.18	CONTRACTUAL ALLOW	446,507.09
NON-COVERD CHARGES	1,520.00	TOTAL MEDICAID LIAB	472,349.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	472,349.09

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	289	0	143,300.00	1,520.00
ROUTINE NURSERY	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	289	0	143,300.00	1,520.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	289	0	143,300.00	1,520.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,264.61	0.00
MED/SURG SUPPLY	66,947.22	0.00
LABORATORY-GENERAL	113,731.00	0.00
RADIOLOGY-DIAGNOSTIC	14,072.66	0.00
CT SCAN	36,996.01	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,729.36	0.00
IV THERAPY	25,486.72	0.00
OPERATING ROOM	25,350.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	35,978.26	0.00
ANESTHESIA	13,137.80	0.00
GI SERVICES	14,560.00	0.00
EMERGENCY ROOM	61,838.58	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 SERVICE	3,054.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41,672.93	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,963.03	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,229.24	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	65.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31,478.82	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	775,556.18	0.00
TOTAL ACCOMODATIONS	143,300.00	1,520.00
TOTAL CHARGES	918,856.18	1,520.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,717,132.16	ADJUSTMENTS	8,086.35
COVERED CHARGES	1,485,830.21	CONTRACTUAL ALLOW	1,135,637.98
NON-COVERD CHARGES	231,301.95	TOTAL MEDICAID LIAB	350,192.23
		LESS: COB	0.00
		LESS: COPAYMENT	789.00
		REIMBURSEMENT	349,403.23
		ALL OTHER	301,088.72
		FEE SCHEDULE-LAB	46,707.79
		INJECTABLE DRUGS	1,606.72

TOTAL NUMBER OF CLAIMS 1,568

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,414.64	1,137.42
MED/SURG SUPPLY	37,827.83	19,186.28
LABORATORY-GENERAL	0.00	100.43
RADIOLOGY-DIAGNOSTIC	85,790.49	1,253.56
CT SCAN	99,676.08	35,827.82
PHYSICAL THERAPY	3,188.12	0.00
EKG/ECG	13,772.50	110.18
IV THERAPY	15,110.09	2,790.05
OPERATING ROOM	259,134.84	29,874.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,204.94	611.20
ANESTHESIA	40,385.90	41,134.59
GI SERVICES	53,757.60	11,700.00
EMERGENCY ROOM	371,511.65	6,105.29
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	39,212.99	2,000.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,757.09	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,234.09	1,234.09
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,963.03	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	33,536.67	1,926.14

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,616.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	274,879.91	69,863.50
MRI SERVICES	21,693.16	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,162.33	6,447.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,485,830.21	231,301.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,485,830.21	231,301.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,531.21	ADJUSTMENTS	0.00
COVERED CHARGES	20,639.44	CONTRACTUAL ALLOW	4,258.14
NON-COVERD CHARGES	1,891.77	TOTAL MEDICAID LIAB	16,381.30
		LESS: COB	16,369.92
		LESS: COPAYMENT	11.38
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	746.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	157.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	273.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,555.13	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,092.28	657.68
EKG/ECG	110.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,680.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	762.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,160.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,142.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	478.01	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,468.18	1,234.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,639.44	1,891.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,639.44	1,891.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	116,755.53	ADJUSTMENTS	52.94
COVERED CHARGES	111,960.63	CONTRACTUAL ALLOW	103,199.93
NON-COVERD CHARGES	4,794.90	TOTAL MEDICAID LIAB	8,760.70
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	8,391.70

TOTAL NUMBER OF CLAIMS 157

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,405.27	36.40
MED/SURG SUPPLY	192.17	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,952.38	0.00
CT SCAN	5,715.12	2,400.57
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	550.90	0.00
IV THERAPY	1,306.76	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	650.00	63.64
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	78,987.24	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,102.77	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	618.93	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,721.48	2,079.65
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	757.61	214.64
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	111,960.63	4,794.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	111,960.63	4,794.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,002.42	ADJUSTMENTS	0.00
COVERED CHARGES	5,068.80	CONTRACTUAL ALLOW	3,362.44
NON-COVERD CHARGES	1,933.62	TOTAL MEDICAID LIAB	1,706.36
		LESS: COB	1,697.36
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	324.64	36.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	887.78	58.24
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	557.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,042.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.17	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,234.09	1,838.98			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,068.80	1,933.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,068.80	1,933.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLINT RIVER HOSPITAL
PO BOX 770
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,891,185.91	ADJUSTMENTS	1,593,714.51
COVERED CHARGES	22,279,092.91	CONTRACTUAL ALLOW	16,039,306.95
NON-COVERD CHARGES	612,093.00	TOTAL MEDICAID LIAB	6,239,785.96
		LESS: COB	55,722.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,184,063.09

TOTAL NUMBER OF ADMISSIONS 685

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,031	21	1,541,279.10	356,315.73
ROUTINE NURSERY	167	3	61,539.10	1,262.40
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,198	24	1,602,818.20	357,578.13
SPECIAL CARE SERVICES				
CCU	477	0	759,306.31	0.00
ICU	0	0	0.00	0.00
NICU	782	0	964,983.83	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,259	0	1,724,290.14	0.00
TOTAL ACCOMODATIONS	4,457	24	3,327,108.34	357,578.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,684,151.77	104.63
MED/SURG SUPPLY	1,732,966.50	4,620.69
LABORATORY-GENERAL	3,681,908.86	6,451.45
RADIOLOGY-DIAGNOSTIC	581,197.80	0.00
CT SCAN	687,796.52	0.00
PHYSICAL THERAPY	85,983.36	0.00
EKG/ECG	178,619.04	0.00
IV THERAPY	1,134,103.84	74,496.31
OPERATING ROOM	1,526,865.98	4,702.90
LABOR/DELIVERY ROOM	119,043.28	0.00
RESPIRATORY SERVICES	708,442.55	2,469.38
ANESTHESIA	196,963.14	0.00
GI SERVICES	24,673.99	0.00
EMERGENCY ROOM	209,378.62	122.43
RECOVERY ROOM	88,275.37	0.00
LABORATORY PATHOLOGIC	116,575.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,267.77	0.00
SPEECH PATHOLOGY	17,915.04	0.00
RENAL DIALYSIS	85,862.39	1,371.60
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	105.86	74,242.65
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	147,712.51	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	138,488.54	6,008.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	209,245.79	41,826.97
AUDIOLOGY	0.00	0.00
CARDIOLOGY	464,531.78	3,312.00
AMBULATORY SURGERY	1,693.35	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,824.31	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	67,564.36	7,336.38

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	101,233.18	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	6,344.25	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	166,498.09	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,751,750.95	23.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	27,425.28

TOTAL ANCILLARY	18,951,984.57	254,514.87
TOTAL ACCOMODATIONS	3,327,108.34	357,578.13
TOTAL CHARGES	22,279,092.91	612,093.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	4410259034254	08/24/10 - 08/24/10	09/27/10	0.00	1,199.00	0.00	0.00	0.00
615	4410259088803	07/18/10 - 07/18/10	09/27/10	0.00	2,036.60	0.00	0.00	0.00
615	4010278037202	09/20/10 - 09/20/10	10/12/10	0.00	2,036.60	0.00	0.00	0.00
3	2210312003848	10/24/10 - 10/27/10	11/15/10	0.00	87.30	0.00	0.00	0.00
615	2010327037921	11/06/10 - 11/09/10	11/29/10	0.00	2,036.60	0.00	0.00	0.00
615	2210328014521	11/08/10 - 11/16/10	11/29/10	0.00	2,036.60	0.00	0.00	0.00
618	2210357016682	12/04/10 - 12/09/10	01/31/11	0.00	1,199.00	0.00	0.00	0.00
615	2211067005245	08/04/10 - 08/11/10	03/14/11	0.00	2,036.60	0.00	0.00	0.00
615	2211094010144	03/18/11 - 03/22/11	04/11/11	0.00	2,545.75	0.00	0.00	0.00
615	2011165059367	09/17/10 - 09/24/10	06/20/11	0.00	2,036.60	0.00	0.00	0.00
615	2011167083396	09/01/10 - 09/03/10	06/20/11	0.00	2,036.60	0.00	0.00	0.00
615	2011178036990	06/21/11 - 06/21/11	07/04/11	0.00	2,545.75	0.00	0.00	0.00
615	2011228062440	04/27/11 - 05/06/11	08/22/11	0.00	2,545.75	0.00	0.00	0.00
282	2211266008865	06/15/11 - 06/24/11	09/26/11	0.00	500.78	0.00	0.00	0.00
615	2011294071765	04/14/11 - 04/27/11	10/31/11	0.00	2,545.75	0.00	0.00	0.00
TOTAL				0.00	27,425.28	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,535.77	ADJUSTMENTS	0.00
COVERED CHARGES	15,515.77	CONTRACTUAL ALLOW	5,236.76
NON-COVERD CHARGES	1,020.00	TOTAL MEDICAID LIAB	10,279.01
		LESS: COB	10,279.01
		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	4	0	2,040.00	1,020.00
ROUTINE NURSERY	4	0	1,683.20	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	3,723.20	1,020.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	3,723.20	1,020.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,812.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,585.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,254.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,000.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,994.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	652.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	492.90	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,792.57	0.00
TOTAL ACCOMODATIONS	3,723.20	1,020.00
TOTAL CHARGES	15,515.77	1,020.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,483,038.85	ADJUSTMENTS	664,126.02
COVERED CHARGES	10,806,712.08	CONTRACTUAL ALLOW	8,903,402.20
NON-COVERD CHARGES	1,676,326.77	TOTAL MEDICAID LIAB	1,903,309.88
		LESS: COB	33,676.10
		LESS: COPAYMENT	3,783.65
		REIMBURSEMENT	1,865,850.13
		ALL OTHER	1,688,579.89
		FEE SCHEDULE-LAB	159,998.33
		INJECTABLE DRUGS	17,271.91

TOTAL NUMBER OF CLAIMS 5,362

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	357,953.36	20,522.95
MED/SURG SUPPLY	295,477.40	11,056.80
LABORATORY-GENERAL	0.00	12,763.06
RADIOLOGY-DIAGNOSTIC	802,897.84	54,225.31
CT SCAN	924,938.48	228,430.39
PHYSICAL THERAPY	13,405.85	8,249.38
EKG/ECG	269,963.41	581.41
IV THERAPY	455,696.99	29,809.96
OPERATING ROOM	1,398,148.91	312,154.25
LABOR/DELIVERY ROOM	53,274.17	765.40
RESPIRATORY SERVICES	66,365.15	2,887.10
ANESTHESIA	246,080.34	0.00
GI SERVICES	42,874.65	2,432.75
EMERGENCY ROOM	1,112,942.60	3,538.48
RECOVERY ROOM	128,444.95	0.00
LABORATORY PATHOLOGIC	0.00	617.00
RADIOLOGY THERAPEUTIC	2,108.80	396.50
OCCUPATIONAL THERAPY	0.00	442.80
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	3,899.62
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	96,698.30	15,443.18
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	483,489.96	50,469.96
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,317.48	9,463.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	245,795.20	59,280.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	190,489.78	92,082.78
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	129,328.96	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	93,341.45	969.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	42,531.28	5,444.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	161.20	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,665,953.91	504,104.92
MRI SERVICES	125,962.00	16,121.89
PROFESSIONAL FEES	0.00	732.48
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	550,069.66	224,327.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,436.35

TOTAL ANCILLARY	10,806,712.08	1,673,649.17
TOTAL ACCOMODATIONS	0.00	2,677.60
TOTAL CHARGES	10,806,712.08	1,676,326.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	4410259106083	08/05/10 - 08/05/10	09/27/10	0.00	1,199.00	0.00	0.00	0.00
7685	2210314005854	10/19/10 - 10/19/10	11/15/10	0.00	757.90	0.00	0.00	0.00
405	2210361003161	12/04/10 - 12/04/10	01/03/11	0.00	174.90	0.00	0.00	0.00
8470	2211173006686	06/12/11 - 06/12/11	06/27/11	0.00	304.55	0.00	0.00	0.00
TOTAL				0.00	2,436.35	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,740.32	ADJUSTMENTS	0.00
COVERED CHARGES	77,175.06	CONTRACTUAL ALLOW	8,653.31
NON-COVERD CHARGES	72,565.26	TOTAL MEDICAID LIAB	68,521.75
		LESS: COB	68,494.24
		LESS: COPAYMENT	27.51
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,048.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,516.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,916.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,912.37	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,832.60	FEE SCHEDULE LAB	20,096.84	10,518.05
EKG/ECG	921.90	0.00	MRI SERVICES	0.00	3,074.10
IV THERAPY	2,494.35	328.84	PROFESSIONAL FEES	0.00	187.50
OPERATING ROOM	4,853.94	31,389.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,944.21	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128.93	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,339.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,432.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,276.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,324.74	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	496.62	7,832.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	731.12	221.91	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	381.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,782.50	88.14			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	627.30	5,365.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,675.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	77,175.06	72,565.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,175.06	72,565.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	837,757.56	ADJUSTMENTS	7,714.35
COVERED CHARGES	750,028.58	CONTRACTUAL ALLOW	709,331.31
NON-COVERD CHARGES	87,728.98	TOTAL MEDICAID LIAB	40,697.27
		LESS: COB	0.00
		LESS: COPAYMENT	1,272.07
		REIMBURSEMENT	39,425.20

TOTAL NUMBER OF CLAIMS 729

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,485.07	102.63
MED/SURG SUPPLY	3,262.63	0.00
LABORATORY-GENERAL	0.00	75.39
RADIOLOGY-DIAGNOSTIC	36,582.35	0.00
CT SCAN	35,095.39	21,389.90
PHYSICAL THERAPY	0.00	179.30
EKG/ECG	14,097.56	0.00
IV THERAPY	40,046.75	5,539.82
OPERATING ROOM	0.00	2,301.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,182.03	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	272.40	0.00
EMERGENCY ROOM	183,375.93	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 SERVICE	39,597.03	4,865.40
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	813.90	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/OBSERV. RM	1,285.98	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,756.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	307,507.07	42,471.28
MRI SERVICES	8,420.63	2,213.30
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	53,247.36	8,590.46
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	750,028.58	87,728.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	750,028.58	87,728.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,096.38	ADJUSTMENTS	0.00
COVERED CHARGES	6,894.98	CONTRACTUAL ALLOW	1,628.46
NON-COVERD CHARGES	201.40	TOTAL MEDICAID LIAB	5,266.52
		LESS: COB	5,260.52
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,526.59	47.70
EKG/ECG	0.00	0.00	MRI SERVICES	2,447.50	0.00
IV THERAPY	790.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,123.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	153.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,894.98	201.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,894.98	201.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,470,891.00	ADJUSTMENTS	37,218.19
COVERED CHARGES	1,391,701.97	CONTRACTUAL ALLOW	1,267,749.40
NON-COVERD CHARGES	79,189.03	TOTAL MEDICAID LIAB	123,952.57
		LESS: COB	0.00
		LESS: COPAYMENT	101.92
		REIMBURSEMENT	123,850.65

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,355.25	386.22
MED/SURG SUPPLY	871,160.99	66.70
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,512.95	6,357.45
CT SCAN	3,411.14	0.00
PHYSICAL THERAPY	0.00	343.40
EKG/ECG	6,241.97	0.00
IV THERAPY	5,181.63	41.34
OPERATING ROOM	282,264.24	57,388.73
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,817.67	0.00
ANESTHESIA	30,965.44	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,209.05	0.00
RECOVERY ROOM	13,393.05	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 SERVICE	4,791.66	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,689.80	2,061.20
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/OBSERV. RM	10,793.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	855.79	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	38,800.23	4,830.52
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,257.67	7,713.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,391,701.97	79,189.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,391,701.97	79,189.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	70,443.70	ADJUSTMENTS	0.00
COVERED CHARGES	57,422.20	CONTRACTUAL ALLOW	-12,724.50
NON-COVERD CHARGES	13,021.50	TOTAL MEDICAID LIAB	70,146.70
		LESS: COB	70,143.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	779.10	412.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54,223.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	338.10	844.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	11,228.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,975.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	535.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	57,422.20	13,021.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,422.20	13,021.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,357,480.35	ADJUSTMENTS	236,815.61
COVERED CHARGES	24,546,504.65	CONTRACTUAL ALLOW	19,374,078.79
NON-COVERD CHARGES	2,810,975.70	TOTAL MEDICAID LIAB	5,172,425.86
		LESS: COB	114,806.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,057,618.90

TOTAL NUMBER OF ADMISSIONS 828

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,857	2	3,408,410.00	2,656,725.00
ROUTINE NURSERY	201	0	136,643.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,058	2	3,545,053.00	2,656,725.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	753	1	1,402,420.00	2,000.00
NICU	11	0	21,505.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	764	1	1,423,925.00	2,000.00
TOTAL ACCOMODATIONS	4,822	3	4,968,978.00	2,658,725.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,624,805.50	250.00
MED/SURG SUPPLY	2,704,741.75	890.00
LABORATORY-GENERAL	4,294,977.12	1,360.00
RADIOLOGY-DIAGNOSTIC	549,513.00	0.00
CT SCAN	1,089,455.00	24,770.00
PHYSICAL THERAPY	192,443.00	0.00
EKG/ECG	253,953.00	0.00
IV THERAPY	915.00	0.00
OPERATING ROOM	738,396.00	1,007.00
LABOR/DELIVERY ROOM	361,168.00	0.00
RESPIRATORY SERVICES	1,247,011.00	107.00
ANESTHESIA	242,240.00	0.00
GI SERVICES	83,078.00	0.00
EMERGENCY ROOM	871,673.00	1,381.00
RECOVERY ROOM	275,829.00	0.00
LABORATORY PATHOLOGIC	151,966.36	0.00
RADIOLOGY THERAPEUTIC	5,027.00	26,535.00
OCCUPATIONAL THERAPY	94,581.00	0.00
SPEECH PATHOLOGY	109,972.00	0.00
RENAL DIALYSIS	104,889.00	28,782.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,455.00	110.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	135,549.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	122,518.25	2,079.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	231,538.00	7,387.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	249,143.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,348.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	150,539.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	191,501.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	267,403.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,181,898.67	57,592.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,577,526.65	152,250.70
TOTAL ACCOMODATIONS	4,968,978.00	2,658,725.00
TOTAL CHARGES	24,546,504.65	2,810,975.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	375,446.00	ADJUSTMENTS	0.00
COVERED CHARGES	360,404.75	CONTRACTUAL ALLOW	210,965.82
NON-COVERD CHARGES	15,041.25	TOTAL MEDICAID LIAB	149,438.93
		LESS: COB	149,438.93
		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	55	0	49,759.00	12,140.00
ROUTINE NURSERY	1	0	497.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	56	0	50,256.00	12,140.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	8	0	13,596.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	13,596.00	0.00
TOTAL ACCOMODATIONS	64	0	63,852.00	12,140.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,660.50	625.00
MED/SURG SUPPLY	58,868.00	306.25
LABORATORY-GENERAL	46,078.00	170.00
RADIOLOGY-DIAGNOSTIC	12,009.00	0.00
CT SCAN	25,044.00	0.00
PHYSICAL THERAPY	682.00	0.00
EKG/ECG	918.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,810.00	0.00
LABOR/DELIVERY ROOM	8,012.00	0.00
RESPIRATORY SERVICES	9,155.00	0.00
ANESTHESIA	4,649.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,947.00	0.00
RECOVERY ROOM	4,747.00	0.00
LABORATORY PATHOLOGIC	1,581.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	422.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	110.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	915.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,290.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,655.25	1,800.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	296,552.75	2,901.25
TOTAL ACCOMODATIONS	63,852.00	12,140.00
TOTAL CHARGES	360,404.75	15,041.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,220,949.54	ADJUSTMENTS	121,120.26
COVERED CHARGES	10,209,193.15	CONTRACTUAL ALLOW	8,351,735.02
NON-COVERD CHARGES	1,011,756.39	TOTAL MEDICAID LIAB	1,857,458.13
		LESS: COB	8,286.03
		LESS: COPAYMENT	2,787.65
		REIMBURSEMENT	1,846,384.45
		ALL OTHER	1,649,306.74
		FEE SCHEDULE-LAB	94,520.36
		INJECTABLE DRUGS	102,557.35

TOTAL NUMBER OF CLAIMS 3,344

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309,445.60	449.00
MED/SURG SUPPLY	337,736.75	105,865.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	590,729.00	17,949.00
CT SCAN	1,054,618.00	96,555.00
PHYSICAL THERAPY	0.00	12,433.00
EKG/ECG	205,147.00	1,377.00
IV THERAPY	56,611.00	368.00
OPERATING ROOM	371,468.22	176,931.83
LABOR/DELIVERY ROOM	34,985.00	5,902.00
RESPIRATORY SERVICES	46,793.00	484.00
ANESTHESIA	210,040.00	0.00
GI SERVICES	20,971.50	4,396.50
EMERGENCY ROOM	2,225,843.84	112,190.16
RECOVERY ROOM	419,674.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,773.00	8,410.00
OCCUPATIONAL THERAPY	0.00	4,702.00
SPEECH PATHOLOGY	0.00	5,012.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	58,280.00	843.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	405,184.75	16,227.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,761.00	1,386.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	329,284.00	45,989.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	87,525.00	25,347.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	20,078.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	223,804.50	6,396.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	178,389.00	1,784.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	568.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,050,631.00	159,985.50
MRI SERVICES	233,312.00	20,051.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	1,161.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	368.00
INJECTABLE DRUGS	722,378.99	180,354.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,209,193.15	1,011,756.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,209,193.15	1,011,756.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	217,222.12	ADJUSTMENTS	0.00
COVERED CHARGES	171,703.84	CONTRACTUAL ALLOW	125,853.26
NON-COVERD CHARGES	45,518.28	TOTAL MEDICAID LIAB	45,850.58
		LESS: COB	45,784.58
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,239.00	0.00
MED/SURG SUPPLY	4,489.50	3,842.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,230.00	734.00
CT SCAN	0.00	15,966.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,175.00	0.00
IV THERAPY	1,528.00	0.00
OPERATING ROOM	8,952.34	7,437.68
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,508.00	0.00
ANESTHESIA	3,918.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	42,364.00	6,980.00
RECOVERY ROOM	12,769.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	343.00	610.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	299.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,533.00	706.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,863.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	818.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,491.00	5,183.60
MRI SERVICES	2,725.00	2,725.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,459.00	1,334.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	171,703.84	45,518.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	171,703.84	45,518.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	593,952.80	ADJUSTMENTS	647.27
COVERED CHARGES	564,485.80	CONTRACTUAL ALLOW	545,894.72
NON-COVERD CHARGES	29,467.00	TOTAL MEDICAID LIAB	18,591.08
		LESS: COB	0.00
		LESS: COPAYMENT	540.05
		REIMBURSEMENT	18,051.03

TOTAL NUMBER OF CLAIMS 333

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,763.00	0.00	OTHER LAB	1,166.00	0.00
MED/SURG SUPPLY	4,708.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,591.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,334.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	145,128.00	8,040.00
EKG/ECG	11,896.00	0.00	MRI SERVICES	6,619.00	0.00
IV THERAPY	2,199.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,037.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	270,003.00	2,748.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,994.80	17,572.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	17,921.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,583.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,290.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,252.00	1,107.00			

TOTAL ANCILLARY	564,485.80	29,467.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	564,485.80	29,467.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,565.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,791.00	CONTRACTUAL ALLOW	5,153.67
NON-COVERD CHARGES	774.00	TOTAL MEDICAID LIAB	3,637.33
		LESS: COB	3,634.33
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	500.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,561.00	34.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,267.00	740.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,373.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,791.00	774.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,791.00	774.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,053,183.48	ADJUSTMENTS	5,203.26
COVERED CHARGES	964,293.16	CONTRACTUAL ALLOW	806,660.46
NON-COVERD CHARGES	88,890.32	TOTAL MEDICAID LIAB	157,632.70
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	157,569.70

TOTAL NUMBER OF CLAIMS 31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,135.50	200.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	258,845.00	30,450.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,718.00	608.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,540.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	341.00	FEE SCHEDULE LAB	52,788.00	1,399.00
EKG/ECG	6,885.00	0.00	MRI SERVICES	2,387.00	0.00
IV THERAPY	5,454.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,775.66	38,800.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,539.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,679.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,971.00	673.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	98,709.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	99,359.50	5,709.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,596.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,086.00	4,114.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,293.00	917.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,052.00	0.00			

TOTAL ANCILLARY	964,293.16	88,890.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	964,293.16	88,890.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,221,120.23	ADJUSTMENTS	74,825.27
COVERED CHARGES	2,183,105.23	CONTRACTUAL ALLOW	971,952.32
NON-COVERD CHARGES	38,015.00	TOTAL MEDICAID LIAB	1,211,152.91
		LESS: COB	2,961.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,208,191.86

TOTAL NUMBER OF ADMISSIONS 245

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	701	0	417,095.00	37,780.00
ROUTINE NURSERY	54	0	30,120.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	755	0	447,215.00	37,780.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	755	0	447,215.00	37,780.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	846,211.23	0.00
MED/SURG SUPPLY	262,679.00	0.00
LABORATORY-GENERAL	188,645.00	0.00
RADIOLOGY-DIAGNOSTIC	39,264.00	0.00
CT SCAN	53,814.00	0.00
PHYSICAL THERAPY	24,353.00	0.00
EKG/ECG	8,050.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	171,377.00	0.00
LABOR/DELIVERY ROOM	16,495.00	0.00
RESPIRATORY SERVICES	44,268.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,465.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	597.00	0.00
SPEECH PATHOLOGY	1,505.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,351.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,372.00	235.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,817.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,516.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17,434.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,136.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,541.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,735,890.23	235.00
TOTAL ACCOMODATIONS	447,215.00	37,780.00
TOTAL CHARGES	2,183,105.23	38,015.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,197.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,387.00	CONTRACTUAL ALLOW	16,965.49
NON-COVERD CHARGES	3,810.00	TOTAL MEDICAID LIAB	22,421.51
		LESS: COB	22,421.51
		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	11	0	6,545.00	3,810.00
ROUTINE NURSERY	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	11	0	6,545.00	3,810.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	6,545.00	3,810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,763.00	0.00	OTHER LAB	364.00	0.00
MED/SURG SUPPLY	6,598.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,317.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	70.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,263.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,424.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,842.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,842.00	0.00
TOTAL ACCOMODATIONS	6,545.00	3,810.00
TOTAL CHARGES	39,387.00	3,810.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,854,477.79	ADJUSTMENTS	42,731.20
COVERED CHARGES	1,706,931.79	CONTRACTUAL ALLOW	1,340,443.54
NON-COVERD CHARGES	147,546.00	TOTAL MEDICAID LIAB	366,488.25
		LESS: COB	34.23
		LESS: COPAYMENT	1,263.00
		REIMBURSEMENT	365,191.02
		ALL OTHER	317,073.45
		FEE SCHEDULE-LAB	48,094.65
		INJECTABLE DRUGS	22.92

TOTAL NUMBER OF CLAIMS 1,498

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	249,921.79	1,688.00
MED/SURG SUPPLY	199,169.00	2,838.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,862.00	1,476.00
CT SCAN	79,037.00	7,808.00
PHYSICAL THERAPY	3,168.00	2,141.00
EKG/ECG	12,250.00	70.00
IV THERAPY	491.00	0.00
OPERATING ROOM	258,281.00	30,663.00
LABOR/DELIVERY ROOM	295.00	0.00
RESPIRATORY SERVICES	13,203.00	242.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	130,504.00	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	207.00	95.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	48,091.00	1,950.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,688.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,454.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	108,905.00	3,354.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,178.00	903.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	482,946.00	93,645.00
MRI SERVICES	19,186.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	95.00	673.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,706,931.79	147,546.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,706,931.79	147,546.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,121.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,953.00	CONTRACTUAL ALLOW	10,990.27
NON-COVERD CHARGES	4,168.00	TOTAL MEDICAID LIAB	10,962.73
		LESS: COB	10,962.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,979.00	0.00
MED/SURG SUPPLY	1,932.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,347.00	0.00
CT SCAN	2,266.00	2,756.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	70.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,121.00	0.00
LABOR/DELIVERY ROOM	36.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	812.00	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 SERVICE	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/OBSERV. RM	986.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,128.00	1,412.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,953.00	4,168.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,953.00	4,168.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,867.00	ADJUSTMENTS	376.58
COVERED CHARGES	63,916.00	CONTRACTUAL ALLOW	58,993.28
NON-COVERD CHARGES	1,951.00	TOTAL MEDICAID LIAB	4,922.72
		LESS: COB	0.00
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	4,778.72

TOTAL NUMBER OF CLAIMS 88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,697.00	0.00
MED/SURG SUPPLY	879.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,891.00	0.00
CT SCAN	4,261.00	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	308.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,289.00	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 SERVICE	262.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	82.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,107.00	1,951.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	63,916.00	1,951.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	63,916.00	1,951.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,448.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,430.00	CONTRACTUAL ALLOW	350.63
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	1,079.37
		LESS: COB	1,079.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	483.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	795.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,430.00	18.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,430.00	18.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,678.00	ADJUSTMENTS	0.00
COVERED CHARGES	74,230.00	CONTRACTUAL ALLOW	59,327.35
NON-COVERD CHARGES	448.00	TOTAL MEDICAID LIAB	14,902.65
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	14,896.65

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,339.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40,280.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,208.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	258.00	FEE SCHEDULE LAB	3,392.00	190.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,369.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	424.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,055.00	0.00			

TOTAL ANCILLARY	74,230.00	448.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,230.00	448.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,241,193.10	ADJUSTMENTS	2,698,600.49
COVERED CHARGES	10,698,460.30	CONTRACTUAL ALLOW	6,438,812.60
NON-COVERD CHARGES	542,732.80	TOTAL MEDICAID LIAB	4,259,647.70
		LESS: COB	231,269.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,028,378.60

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,273	0	3,551,205.00	182,044.00
ROUTINE NURSERY	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	3,273	0	3,551,205.00	182,044.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	53	0	120,734.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	53	0	120,734.00	0.00
TOTAL ACCOMODATIONS	3,326	0	3,671,939.00	182,044.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,667,771.64	4,612.80
MED/SURG SUPPLY	1,482,390.95	0.00
LABORATORY-GENERAL	247,878.00	8,718.00
RADIOLOGY-DIAGNOSTIC	106,289.00	0.00
CT SCAN	28,026.00	0.00
PHYSICAL THERAPY	846,068.00	43,572.00
EKG/ECG	5,368.00	0.00
IV THERAPY	0.00	2,144.00
OPERATING ROOM	356,296.11	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	765,544.00	74,573.00
ANESTHESIA	96.00	0.00
GI SERVICES	1,073.00	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	841,049.00	27,846.00
SPEECH PATHOLOGY	263,637.00	8,063.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	6,881.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,073.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,636.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,539.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,200.00	0.00
AMBULATORY SURGERY	5,071.00	9,240.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,218.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,956.00	459.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	96,910.00	0.00
RECREATIONAL THERAPY	123,804.00	92,785.00
EDUCATION & TRAINING	118,743.00	45,073.00
OTHER THERAPEUTIC SVC	612.00	14,987.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,270.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,002.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	2,320.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	19,415.00

TOTAL ANCILLARY	7,026,521.30	360,688.80
TOTAL ACCOMODATIONS	3,671,939.00	182,044.00
TOTAL CHARGES	10,698,460.30	542,732.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
952	4010266076865	07/01/10 - 07/01/10	09/27/10	0.00	200.00	0.00	0.00	0.00
952	4010272022291	07/22/10 - 07/22/10	10/04/10	0.00	500.00	0.00	0.00	0.00
952	4010285041263	09/02/10 - 09/02/10	10/18/10	0.00	678.00	0.00	0.00	0.00
952	5210333000026	06/10/10 - 06/10/10	12/06/10	0.00	400.00	0.00	0.00	0.00
952	5210342000020	08/16/10 - 08/16/10	12/13/10	0.00	200.00	0.00	0.00	0.00
952	5211034002600	07/07/10 - 08/26/10	02/07/11	0.00	200.00	0.00	0.00	0.00
952	5211034002602	10/13/10 - 11/17/10	02/07/11	0.00	456.00	0.00	0.00	0.00
952	5211036000075	09/08/10 - 10/26/10	02/14/11	0.00	1,378.00	0.00	0.00	0.00
952	2011049070253	01/17/11 - 02/09/11	02/21/11	0.00	450.00	0.00	0.00	0.00
952	5211053000031	10/01/10 - 11/04/10	02/28/11	0.00	896.00	0.00	0.00	0.00
952	5211053000037	11/05/10 - 12/15/10	02/28/11	0.00	842.00	0.00	0.00	0.00
952	5211055002380	12/03/10 - 02/03/11	03/19/12	0.00	200.00	0.00	0.00	0.00
952	2011110023596	02/09/11 - 04/12/11	04/25/11	0.00	1,371.00	0.00	0.00	0.00
952	2211111011595	02/04/11 - 03/25/11	04/25/11	0.00	1,142.00	0.00	14,635.37	0.00
952	2011123032639	02/24/11 - 03/30/11	05/09/11	0.00	464.00	0.00	0.00	0.00
952	2011132029055	03/03/11 - 03/30/11	05/16/11	0.00	450.00	0.00	0.00	0.00
952	5211140002895	08/16/10 - 09/29/10	05/30/11	0.00	1,956.00	0.00	0.00	0.00
952	2011179027080	02/23/11 - 06/02/11	07/04/11	0.00	1,408.00	0.00	0.00	0.00
952	5211189003645	02/04/11 - 03/16/11	07/18/11	0.00	514.00	0.00	0.00	0.00
952	5211189003653	12/21/10 - 02/10/11	07/18/11	0.00	378.00	0.00	0.00	0.00
952	5211189003659	12/20/10 - 01/19/11	07/18/11	0.00	478.00	0.00	0.00	0.00
952	5211215010137	11/02/10 - 12/13/10	08/08/11	0.00	2,160.00	0.00	0.00	0.00
952	5211265000821	11/12/10 - 12/23/10	09/26/11	0.00	1,784.00	0.00	0.00	0.00
952	2211297001277	02/25/11 - 04/06/11	10/31/11	0.00	546.00	0.00	0.00	0.00
952	5212130000001	12/23/10 - 01/26/11	05/14/12	0.00	364.00	0.00	0.00	0.00
TOTAL				0.00	19,415.00	0.00	14,635.37	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	679,890.57	ADJUSTMENTS	0.00
COVERED CHARGES	661,796.02	CONTRACTUAL ALLOW	298,505.15
NON-COVERD CHARGES	18,094.55	TOTAL MEDICAID LIAB	363,290.87
		LESS: COB	363,290.87
		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	130	0	141,050.00	7,020.00
ROUTINE NURSERY	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	130	0	141,050.00	7,020.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	8	0	18,224.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	18,224.00	0.00
TOTAL ACCOMODATIONS	138	0	159,274.00	7,020.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,349.00	103.55
MED/SURG SUPPLY	151,104.02	0.00
LABORATORY-GENERAL	13,920.00	525.00
RADIOLOGY-DIAGNOSTIC	3,364.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	36,532.00	0.00
EKG/ECG	244.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	36,587.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	56,287.00	4,231.00
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	22,355.00	0.00
SPEECH PATHOLOGY	14,028.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,084.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	1,155.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	153.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,195.00	0.00
RECREATIONAL THERAPY	3,772.00	1,409.00
EDUCATION & TRAINING	2,701.00	2,830.00
OTHER THERAPEUTIC SVC	0.00	480.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	60.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	128.00

TOTAL ANCILLARY	502,522.02	11,074.55
TOTAL ACCOMODATIONS	159,274.00	7,020.00
TOTAL CHARGES	661,796.02	18,094.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
952	2211062015334	12/17/10 - 01/19/11	03/07/11	0.00	128.00	0.00	52,657.75	0.00
TOTAL				0.00	128.00	0.00	52,657.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,223,239.07	ADJUSTMENTS	190,581.36
COVERED CHARGES	1,656,538.02	CONTRACTUAL ALLOW	987,126.84
NON-COVERD CHARGES	566,701.05	TOTAL MEDICAID LIAB	669,411.18
		LESS: COB	3,093.25
		LESS: COPAYMENT	4,518.00
		REIMBURSEMENT	661,799.93
		ALL OTHER	516,609.14
		FEE SCHEDULE-LAB	15,778.63
		INJECTABLE DRUGS	129,412.16

TOTAL NUMBER OF CLAIMS 1,525

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,135.24	282.90	OTHER LAB	30,412.00	4,037.00
MED/SURG SUPPLY	27,660.83	0.00	RECREATIONAL THERAPY	40,236.00	0.00
LABORATORY-GENERAL	0.00	466.00	EDUCATION & TRAINING	15,648.00	1,162.00
RADIOLOGY-DIAGNOSTIC	38,852.00	1,690.00	OTHER THERAPEUTIC SVC	0.00	2,479.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	141,860.30	51,770.00	FEE SCHEDULE LAB	137,355.00	2,232.00
EKG/ECG	3,904.00	0.00	MRI SERVICES	337,724.00	25,928.00
IV THERAPY	37,418.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	291.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	610.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	375,458.65	382,644.15
RADIOLOGY THERAPEUTIC	31,164.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,508.00	55,040.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	40,103.00	11,327.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	645.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	226,728.00	24,756.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	19,743.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	13,529.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,808.00	1,632.00			

TOTAL ANCILLARY	1,656,538.02	566,701.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,656,538.02	566,701.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/10	THROUGH	03/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/10 THROUGH 03/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,252,097.45	ADJUSTMENTS	1,724,326.36
COVERED CHARGES	45,705,774.05	CONTRACTUAL ALLOW	36,841,050.66
NON-COVERD CHARGES	546,323.40	TOTAL MEDICAID LIAB	8,864,723.39
		LESS: COB	66,861.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,797,862.33

TOTAL NUMBER OF ADMISSIONS 2,244

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,067	2	3,251,221.00	204,212.30
ROUTINE NURSERY	2,689	0	3,213,029.70	6,862.70
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	549.90
TOTAL ROUTINE	5,756	4	6,464,250.70	211,624.90
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	781	0	2,167,853.00	17,001.00
NICU	273	0	1,125,233.20	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,054	0	3,293,086.20	17,001.00
TOTAL ACCOMODATIONS	6,810	4	9,757,336.90	228,625.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,781,965.90	63,284.30
MED/SURG SUPPLY	6,106,118.05	55,548.30
LABORATORY-GENERAL	4,280,165.90	18,261.40
RADIOLOGY-DIAGNOSTIC	327,174.80	1,061.90
CT SCAN	781,631.20	22,207.40
PHYSICAL THERAPY	138,243.40	43,783.90
EKG/ECG	105,348.10	0.00
IV THERAPY	28,939.40	0.00
OPERATING ROOM	2,786,382.30	5,184.70
LABOR/DELIVERY ROOM	5,392,167.70	10,804.30
RESPIRATORY SERVICES	1,406,421.10	4,802.00
ANESTHESIA	821,540.30	2,094.80
GI SERVICES	136,114.90	0.00
EMERGENCY ROOM	594,980.90	23,414.90
RECOVERY ROOM	1,201,248.80	1,543.70
LABORATORY PATHOLOGIC	225,390.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	72,459.60	23,412.80
SPEECH PATHOLOGY	93,769.60	31,667.50
RENAL DIALYSIS	37,631.70	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,472.40	561.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	201,220.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	271,406.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	129,117.50	0.00
AUDIOLOGY	320,425.20	0.00
CARDIOLOGY	302,986.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,814.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	111,589.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	81,346.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	135.60	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	172,598.80	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,631.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	10,064.20
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,948,437.15	317,697.50
TOTAL ACCOMODATIONS	9,757,336.90	228,625.90
TOTAL CHARGES	45,705,774.05	546,323.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,557.70	ADJUSTMENTS	0.00
COVERED CHARGES	110,065.50	CONTRACTUAL ALLOW	96,020.16
NON-COVERD CHARGES	492.20	TOTAL MEDICAID LIAB	14,045.34
		LESS: COB	14,045.34
		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	14	0	15,342.00	492.20
ROUTINE NURSERY	2	0	1,186.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16	0	16,528.00	492.20
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	16	0	16,528.00	492.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,562.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,797.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,668.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,742.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,370.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,425.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,543.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,014.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	328.20	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,537.50	0.00
TOTAL ACCOMODATIONS	16,528.00	492.20
TOTAL CHARGES	110,065.50	492.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,830,221.72	ADJUSTMENTS	228,893.41
COVERED CHARGES	6,990,958.14	CONTRACTUAL ALLOW	5,804,631.11
NON-COVERD CHARGES	839,263.58	TOTAL MEDICAID LIAB	1,186,327.03
		LESS: COB	15,403.20
		LESS: COPAYMENT	1,383.00
		REIMBURSEMENT	1,169,540.83
		ALL OTHER	1,112,855.62
		FEE SCHEDULE-LAB	51,225.33
		INJECTABLE DRUGS	5,459.88

TOTAL NUMBER OF CLAIMS 2,217

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,654.90	13,744.00
MED/SURG SUPPLY	424,543.80	71,164.90
LABORATORY-GENERAL	0.00	16.60
RADIOLOGY-DIAGNOSTIC	323,362.60	3,199.90
CT SCAN	910,553.50	91,808.70
PHYSICAL THERAPY	5,808.90	4,178.80
EKG/ECG	89,096.50	1,167.10
IV THERAPY	111,169.90	23,225.10
OPERATING ROOM	271,316.51	15,454.89
LABOR/DELIVERY ROOM	5,565.80	0.00
RESPIRATORY SERVICES	22,262.20	790.20
ANESTHESIA	58,463.70	0.00
GI SERVICES	3,445.20	0.00
EMERGENCY ROOM	1,678,694.40	35,870.80
RECOVERY ROOM	75,630.50	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	13,073.00	2,002.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	337,229.80	29,123.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,655.40	2,437.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	59,112.70	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,564.80	0.00
AMBULATORY SURGERY	54,768.60	28,661.20
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,942.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	138,579.70	894.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	44,713.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	67.80
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,453,037.91	416,260.09
MRI SERVICES	107,247.70	4,507.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	9,835.10
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	471,464.12	83,008.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	1,533.30
NO CC/INVALID REV CODE	0.00	311.20

TOTAL ANCILLARY	6,990,958.14	839,263.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,990,958.14	839,263.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	5911363000076	07/19/11 - 07/19/11	01/02/12	0.00	311.20	0.00	0.00	0.00
TOTAL				0.00	311.20	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	141,086.80	ADJUSTMENTS	0.00
COVERED CHARGES	122,036.20	CONTRACTUAL ALLOW	91,908.91
NON-COVERD CHARGES	19,050.60	TOTAL MEDICAID LIAB	30,127.29
		LESS: COB	30,115.29
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	914.80	143.90
MED/SURG SUPPLY	5,703.10	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,136.10	0.00
CT SCAN	7,552.20	6,369.60
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,736.40	0.00
IV THERAPY	6,413.00	0.00
OPERATING ROOM	985.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,055.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	35,273.30	375.50
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	284.70	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,901.50	817.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	1,005.50	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,394.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,423.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,202.00	4,330.50
MRI SERVICES	0.00	5,919.20
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,054.80	1,094.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	122,036.20	19,050.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	122,036.20	19,050.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	559,272.60	ADJUSTMENTS	220.76
COVERED CHARGES	517,975.60	CONTRACTUAL ALLOW	504,661.94
NON-COVERD CHARGES	41,297.00	TOTAL MEDICAID LIAB	13,313.66
		LESS: COB	0.00
		LESS: COPAYMENT	351.01
		REIMBURSEMENT	12,962.65

TOTAL NUMBER OF CLAIMS 238

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,914.10	0.00
MED/SURG SUPPLY	17,606.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,545.40	425.70
CT SCAN	12,938.50	14,116.40
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,668.40	0.00
IV THERAPY	7,986.90	2,347.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,993.90	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	241,164.30	3,022.80
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	338.70
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,484.20	6,264.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,358.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,853.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,139.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	112,002.10	6,778.60
MRI SERVICES	7,541.80	2,859.30
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,779.00	5,144.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	517,975.60	41,297.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	517,975.60	41,297.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,114.40	ADJUSTMENTS	0.00
COVERED CHARGES	32,201.50	CONTRACTUAL ALLOW	21,925.57
NON-COVERD CHARGES	912.90	TOTAL MEDICAID LIAB	10,275.93
		LESS: COB	10,266.93
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,967.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,376.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,693.60	555.30
EKG/ECG	569.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,245.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,267.60	357.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,201.50	912.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,201.50	912.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	887,239.70	ADJUSTMENTS	15,296.55
COVERED CHARGES	782,368.46	CONTRACTUAL ALLOW	665,659.34
NON-COVERD CHARGES	104,871.24	TOTAL MEDICAID LIAB	116,709.12
		LESS: COB	4,528.71
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	112,138.41

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,812.90	382.50
MED/SURG SUPPLY	183,785.80	26,126.10
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,882.90	890.80
CT SCAN	28,237.20	5,833.80
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,070.60	0.00
IV THERAPY	15,435.50	12,128.80
OPERATING ROOM	168,400.55	30,172.35
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,670.90	0.00
ANESTHESIA	41,818.70	0.00
GI SERVICES	5,340.00	0.00
EMERGENCY ROOM	34,244.60	1,502.00
RECOVERY ROOM	40,517.80	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	332.80
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	22,974.80	0.00
OTHER IMAGING SERVICE	12,394.10	1,159.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,551.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,563.80	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,525.90	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/OBSERV. RM	12,710.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	62,969.21	11,039.09
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	58,461.00	15,304.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	782,368.46	104,871.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	782,368.46	104,871.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
4660 COMMUNICATION AVE
BOCA RATON,FL 33431-4487

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,462,002.18	ADJUSTMENTS	193,181.52
COVERED CHARGES	4,336,180.68	CONTRACTUAL ALLOW	3,044,043.26
NON-COVERD CHARGES	125,821.50	TOTAL MEDICAID LIAB	1,292,137.42
		LESS: COB	278.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,291,858.71

TOTAL NUMBER OF ADMISSIONS 130

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	253	0	142,692.00	78,928.00
ROUTINE NURSERY	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	142,692.00	78,928.00
SPECIAL CARE SERVICES				
CCU	236	0	253,738.00	0.00
ICU	146	0	390,776.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	382	0	644,514.00	0.00
TOTAL ACCOMODATIONS	635	0	787,206.00	78,928.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380,740.45	0.00
MED/SURG SUPPLY	232,939.48	0.00
LABORATORY-GENERAL	757,923.50	122.75
RADIOLOGY-DIAGNOSTIC	130,597.75	0.00
CT SCAN	181,900.25	13,174.25
PHYSICAL THERAPY	19,063.50	0.00
EKG/ECG	41,142.50	0.00
IV THERAPY	20,157.75	0.00
OPERATING ROOM	192,475.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	202,856.75	0.00
ANESTHESIA	54,411.00	0.00
GI SERVICES	6,821.25	0.00
EMERGENCY ROOM	121,681.50	0.00
RECOVERY ROOM	24,657.00	0.00
LABORATORY PATHOLOGIC	9,164.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,677.75	0.00
SPEECH PATHOLOGY	3,839.50	0.00
RENAL DIALYSIS	13,343.75	9,391.25
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	40.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	46,006.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	32,833.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	33,212.00	1,829.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	113,689.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,197.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,064.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	22,676.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	544.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	42,790.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	20,606.00
INJECTABLE DRUGS	846,072.50	1,225.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,548,974.68	46,893.50
TOTAL ACCOMODATIONS	787,206.00	78,928.00
TOTAL CHARGES	4,336,180.68	125,821.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,674,477.38	ADJUSTMENTS	80,743.37
COVERED CHARGES	2,367,766.37	CONTRACTUAL ALLOW	1,906,811.47
NON-COVERD CHARGES	306,711.01	TOTAL MEDICAID LIAB	460,954.90
		LESS: COB	743.75
		LESS: COPAYMENT	690.00
		REIMBURSEMENT	459,521.15
		ALL OTHER	425,281.49
		FEE SCHEDULE-LAB	30,416.26
		INJECTABLE DRUGS	3,823.40

TOTAL NUMBER OF CLAIMS 1,171

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,723.00	242.50
MED/SURG SUPPLY	87,630.63	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228,210.25	7,408.25
CT SCAN	308,356.75	81,212.25
PHYSICAL THERAPY	7,318.25	2,286.75
EKG/ECG	41,236.50	0.00
IV THERAPY	33,256.50	0.00
OPERATING ROOM	152,919.49	110,700.53
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,499.00	2,323.50
ANESTHESIA	73,051.50	0.00
GI SERVICES	11,684.75	2,104.25
EMERGENCY ROOM	641,273.75	4,831.00
RECOVERY ROOM	56,667.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,351.00	639.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,351.00	2,184.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	27,980.00	15,421.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,381.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	41,376.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,918.50	853.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,716.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	156.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	405,711.00	47,557.75
MRI SERVICES	34,917.75	3,419.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	48,235.00	25,369.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,367,766.37	306,711.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,367,766.37	306,711.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,457.75	ADJUSTMENTS	0.00
COVERED CHARGES	34,545.25	CONTRACTUAL ALLOW	22,880.60
NON-COVERD CHARGES	1,912.50	TOTAL MEDICAID LIAB	11,664.65
		LESS: COB	11,655.65
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,392.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	994.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,904.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,346.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,629.00	993.75
EKG/ECG	629.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	347.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,831.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,662.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,792.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,566.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,435.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.25	878.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	40.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	34,545.25	1,912.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,545.25	1,912.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	352,752.50	ADJUSTMENTS	2,268.48
COVERED CHARGES	332,127.75	CONTRACTUAL ALLOW	313,095.44
NON-COVERD CHARGES	20,624.75	TOTAL MEDICAID LIAB	19,032.31
		LESS: COB	0.00
		LESS: COPAYMENT	612.01
		REIMBURSEMENT	18,420.30

TOTAL NUMBER OF CLAIMS 340

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,755.50	0.00
MED/SURG SUPPLY	889.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,681.25	0.00
CT SCAN	22,031.25	13,802.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,100.50	0.00
IV THERAPY	3,427.75	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	518.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	199,430.50	460.50
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	40.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,268.75	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/OBSERV. RM	159.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	79.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60,245.00	3,048.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,621.00	3,193.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	332,127.75	20,624.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	332,127.75	20,624.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	132,261.50	ADJUSTMENTS	5,477.56
COVERED CHARGES	122,966.58	CONTRACTUAL ALLOW	101,213.03
NON-COVERD CHARGES	9,294.92	TOTAL MEDICAID LIAB	21,753.55
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	21,738.55

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,731.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35,465.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,857.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	692.25	FEE SCHEDULE LAB	4,450.00	0.00
EKG/ECG	1,212.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,097.58	7,775.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,225.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,029.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,004.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,115.75	677.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	150.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,778.50	0.00			

TOTAL ANCILLARY	122,966.58	9,294.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	122,966.58	9,294.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,465,698.94	ADJUSTMENTS	149,060.66
COVERED CHARGES	1,451,226.69	CONTRACTUAL ALLOW	1,105,549.19
NON-COVERD CHARGES	14,472.25	TOTAL MEDICAID LIAB	345,677.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	345,677.50

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	81	0	63,990.00	11,585.00
ROUTINE NURSERY	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	81	0	63,990.00	11,585.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,362.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	3,362.00	0.00
TOTAL ACCOMODATIONS	83	0	67,352.00	11,585.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,929.75	0.00	OTHER LAB	4,125.15	0.00
MED/SURG SUPPLY	830,472.75	475.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,540.72	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,152.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,969.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,193.37	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,005.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	267,491.72	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,121.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,727.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,008.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,993.00	2,412.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,200.37	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,944.64	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,383,874.69	2,887.25
TOTAL ACCOMODATIONS	67,352.00	11,585.00
TOTAL CHARGES	1,451,226.69	14,472.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/10	THROUGH	06/30/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	296,057.98	ADJUSTMENTS	13,327.97
COVERED CHARGES	225,826.87	CONTRACTUAL ALLOW	176,979.01
NON-COVERD CHARGES	70,231.11	TOTAL MEDICAID LIAB	48,847.86
		LESS: COB	18.95
		LESS: COPAYMENT	127.30
		REIMBURSEMENT	48,701.61
		ALL OTHER	47,561.49
		FEE SCHEDULE-LAB	1,013.05
		INJECTABLE DRUGS	127.07

TOTAL NUMBER OF CLAIMS 50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,188.50	151.00
MED/SURG SUPPLY	18,723.00	29,920.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,455.50	0.00
CT SCAN	6,789.75	1,830.00
PHYSICAL THERAPY	0.00	1,924.86
EKG/ECG	2,005.08	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	85,938.43	23,057.65
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	330.65
ANESTHESIA	27,384.39	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	18,307.25	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,663.16	11,588.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,336.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,424.06	384.25
MRI SERVICES	28,441.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,170.50	1,044.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	225,826.87	70,231.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	225,826.87	70,231.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,545.89	ADJUSTMENTS	0.00
COVERED CHARGES	24,400.48	CONTRACTUAL ALLOW	19,079.11
NON-COVERD CHARGES	6,145.41	TOTAL MEDICAID LIAB	5,321.37
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,321.37

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,939.50	0.00
MED/SURG SUPPLY	11,641.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	254.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	147.23
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,872.18	5,872.18
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,768.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,879.10	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	126.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,400.48	6,145.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,400.48	6,145.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,328,655.88	ADJUSTMENTS	692,748.24
COVERED CHARGES	5,760,193.45	CONTRACTUAL ALLOW	3,739,386.26
NON-COVERD CHARGES	568,462.43	TOTAL MEDICAID LIAB	2,020,807.19
		LESS: COB	35,634.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,985,172.66

TOTAL NUMBER OF ADMISSIONS 85

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,497	0	2,223,352.00	403,188.00
ROUTINE NURSERY	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	1,497	0	2,223,352.00	403,188.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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	48	0.00	73,800.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	48	0.00	73,800.00
TOTAL ACCOMODATIONS	1,497	48	2,223,352.00	476,988.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	452,472.52	1,696.00	OTHER LAB	22,300.00	0.00
MED/SURG SUPPLY	353,127.00	24,064.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	494,740.00	14,462.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,107.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,282.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	164,674.00	2,418.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,756.00	0.00	MRI SERVICES	2,453.00	0.00
IV THERAPY	90.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,353.00	2,698.00	DURABLE MED. EQUIP.	0.00	3,360.60
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	810,714.00	4,768.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,671.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	563,300.93	29,895.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	241,686.00	4,915.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	134,876.00	3,011.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	58,222.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	19,875.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	7,130.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,604.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,374.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,536,841.45	91,474.43
TOTAL ACCOMODATIONS	2,223,352.00	476,988.00
TOTAL CHARGES	5,760,193.45	568,462.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	9111250000181	12/22/10 - 12/22/10	09/12/11	0.00	0.00	0.00	1,313.89	0.00
TOTAL				0.00	0.00	0.00	1,313.89	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/10	THROUGH	08/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	351,997.32	ADJUSTMENTS	2,975.47
COVERED CHARGES	297,405.32	CONTRACTUAL ALLOW	173,711.44
NON-COVERD CHARGES	54,592.00	TOTAL MEDICAID LIAB	123,693.88
		LESS: COB	280.00
		LESS: COPAYMENT	822.00
		REIMBURSEMENT	122,591.88
		ALL OTHER	121,719.20
		FEE SCHEDULE-LAB	872.68
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 323

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126.32	0.00
MED/SURG SUPPLY	9,634.00	150.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,514.00	836.00
CT SCAN	0.00	7,914.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	336.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	75,243.00	42,406.00
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	1,364.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	28,585.00	1,018.00
PSYCHIATRIC SERVICES	42,930.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	129,610.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,427.00	884.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	20.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	297,405.32	54,592.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	297,405.32	54,592.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,833.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,439.00	CONTRACTUAL ALLOW	4,179.38
NON-COVERD CHARGES	1,394.00	TOTAL MEDICAID LIAB	15,259.62
		LESS: COB	15,190.62
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,346.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,154.00	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	18,285.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,439.00	1,394.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,439.00	1,394.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP
PO BOX 403021
ATLANTA,GA 30384-3021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	838,041.60	ADJUSTMENTS	131,992.63
COVERED CHARGES	756,150.60	CONTRACTUAL ALLOW	237,259.78
NON-COVERD CHARGES	81,891.00	TOTAL MEDICAID LIAB	518,890.82
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	518,890.82

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	357	68	299,880.00	81,891.00
ROUTINE NURSERY	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	357	68	299,880.00	81,891.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	357	68	299,880.00	81,891.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,551.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66,344.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,963.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,904.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,396.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,319.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	89,370.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,423.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	456,270.60	0.00
TOTAL ACCOMODATIONS	299,880.00	81,891.00
TOTAL CHARGES	756,150.60	81,891.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	144,318.50	ADJUSTMENTS	2,193.02
COVERED CHARGES	111,031.00	CONTRACTUAL ALLOW	84,663.39
NON-COVERD CHARGES	33,287.50	TOTAL MEDICAID LIAB	26,367.61
		LESS: COB	0.00
		LESS: COPAYMENT	921.00
		REIMBURSEMENT	25,446.61
		ALL OTHER	25,446.61
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 196

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	138.00	0.00
RADIOLOGY-DIAGNOSTIC	1,398.00	566.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,512.00	8,904.00	FEE SCHEDULE LAB	0.00	522.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	3,709.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,718.00	6,402.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,379.00	6,762.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,158.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,396.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	59,332.00	6,422.00			

TOTAL ANCILLARY	111,031.00	33,287.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	111,031.00	33,287.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	542.00	ADJUSTMENTS	0.00
COVERED CHARGES	542.00	CONTRACTUAL ALLOW	216.08
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	325.92
		LESS: COB	325.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	542.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	542.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	542.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WALTON REHABILITATION HOSPITAL
PO BOX 2223
AUGUSTA,GA 30903-2223

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,211,838.83	ADJUSTMENTS	173,858.45
COVERED CHARGES	15,184,976.83	CONTRACTUAL ALLOW	10,267,866.81
NON-COVERD CHARGES	2,026,862.00	TOTAL MEDICAID LIAB	4,917,110.02
		LESS: COB	21,429.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,895,680.06

TOTAL NUMBER OF ADMISSIONS 74

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,192	181	1,888,975.00	1,456,793.00
ROUTINE NURSERY	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	2,192	181	1,888,975.00	1,456,793.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	767	0	1,488,853.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	767	0	1,488,853.00	0.00
TOTAL ACCOMODATIONS	2,959	181	3,377,828.00	1,456,793.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,191,546.50	0.00
MED/SURG SUPPLY	1,649,902.30	0.00
LABORATORY-GENERAL	1,280,552.59	0.00
RADIOLOGY-DIAGNOSTIC	169,740.00	0.00
CT SCAN	13,332.00	0.00
PHYSICAL THERAPY	108,194.00	0.00
EKG/ECG	17,112.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	382,638.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,370,721.00	558,975.00
ANESTHESIA	67,530.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	48,784.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	109,936.00	0.00
SPEECH PATHOLOGY	145,347.50	0.00
RENAL DIALYSIS	38,185.00	10,910.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,076.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	138,586.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,552.94	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,428.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,291.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	25,192.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,500.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	184.00

TOTAL ANCILLARY	11,807,148.83	570,069.00
TOTAL ACCOMODATIONS	3,377,828.00	1,456,793.00
TOTAL CHARGES	15,184,976.83	2,026,862.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
1	2211175012972	05/26/11 - 06/23/11	06/27/11	0.00	184.00	0.00	0.00	0.00
TOTAL				0.00	184.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/10 THROUGH 08/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,497,826.68	ADJUSTMENTS	60,755.38
COVERED CHARGES	5,354,701.81	CONTRACTUAL ALLOW	3,318,748.87
NON-COVERD CHARGES	143,124.87	TOTAL MEDICAID LIAB	2,035,952.94
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,035,952.94

TOTAL NUMBER OF ADMISSIONS 374

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,115	6	966,560.00	135,184.81
ROUTINE NURSERY	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	1,115	6	966,560.00	135,184.81
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,115	6	966,560.00	135,184.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480,230.46	6.50
MED/SURG SUPPLY	181,824.23	205.06
LABORATORY-GENERAL	390,722.93	168.00
RADIOLOGY-DIAGNOSTIC	64,644.40	0.00
CT SCAN	5,395.00	0.00
PHYSICAL THERAPY	3,343.20	0.00
EKG/ECG	5,188.80	0.00
IV THERAPY	351.70	0.00
OPERATING ROOM	106,625.20	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,571,219.92	1,020.80
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	453,208.90	917.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	152.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	299.70	0.00
SPEECH PATHOLOGY	1,853.20	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	5,547.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	21,217.90	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	47,051.30	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	540.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,452.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	16,021.00	0.00
PROFESSIONAL FEES	0.00	75.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,798.47	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,388,141.81	7,940.06
TOTAL ACCOMODATIONS	966,560.00	135,184.81
TOTAL CHARGES	5,354,701.81	143,124.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,717,967.34	ADJUSTMENTS	229,516.27
COVERED CHARGES	9,377,676.77	CONTRACTUAL ALLOW	6,295,485.34
NON-COVERD CHARGES	340,290.57	TOTAL MEDICAID LIAB	3,082,191.43
		LESS: COB	1,363.84
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	3,080,821.59
		ALL OTHER	2,807,806.51
		FEE SCHEDULE-LAB	209,383.13
		INJECTABLE DRUGS	63,631.95

TOTAL NUMBER OF CLAIMS 11,108

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	224,615.75	15,822.68
MED/SURG SUPPLY	352,425.31	403.23
LABORATORY-GENERAL	0.00	342.00
RADIOLOGY-DIAGNOSTIC	210,084.68	7,231.40
CT SCAN	28,054.30	12,671.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	23,115.20	400.40
IV THERAPY	2,232.20	0.00
OPERATING ROOM	96,787.60	2,356.70
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,101,511.30	71,864.20
ANESTHESIA	442.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,045,665.40	18,636.40
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	1,189,616.44	9,972.80
PSYCHIATRIC SERVICES	317.20	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	43,693.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	882,845.30	5,846.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,182.20	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/OBSERV. RM	91,155.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	105,177.90	119.60
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	193.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,812,512.04	155,799.22
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	268.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	162,243.49	38,362.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,377,676.77	340,290.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,377,676.77	340,290.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,172.94	ADJUSTMENTS	0.00
COVERED CHARGES	15,871.94	CONTRACTUAL ALLOW	14,396.82
NON-COVERD CHARGES	2,301.00	TOTAL MEDICAID LIAB	1,475.12
		LESS: COB	1,475.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	476.26	0.00
MED/SURG SUPPLY	1,157.18	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	318.90	0.00
CT SCAN	0.00	1,079.00
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	2,961.20	1,003.80
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,605.40	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	1,485.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	984.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,884.00	218.20
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,871.94	2,301.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,871.94	2,301.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	921,892.79	ADJUSTMENTS	391.58
COVERED CHARGES	901,377.33	CONTRACTUAL ALLOW	814,477.88
NON-COVERD CHARGES	20,515.46	TOTAL MEDICAID LIAB	86,899.45
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	86,896.45
		TOTAL NUMBER OF CLAIMS	1,554

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,960.12	5,090.45
MED/SURG SUPPLY	12,037.33	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,330.90	639.70
CT SCAN	1,480.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,001.00	0.00
IV THERAPY	519.40	0.00
OPERATING ROOM	3,941.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	38,311.70	2,213.80
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	734,030.20	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 SERVICE	765.70	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/OBSERV. RM	2,132.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	80,542.58	11,688.35
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	324.90	396.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	901,377.33	20,515.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	901,377.33	20,515.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,743.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,381.00	CONTRACTUAL ALLOW	1,219.00
NON-COVERD CHARGES	362.00	TOTAL MEDICAID LIAB	162.00
		LESS: COB	162.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	407.00	362.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	974.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,381.00	362.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,381.00	362.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,184.43	ADJUSTMENTS	0.00
COVERED CHARGES	56,671.35	CONTRACTUAL ALLOW	43,749.29
NON-COVERD CHARGES	2,513.08	TOTAL MEDICAID LIAB	12,922.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,922.06

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,627.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,003.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,725.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,057.00	549.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,033.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,779.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,542.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	239.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,968.00	0.00			

TOTAL ANCILLARY	56,671.35	2,513.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,671.35	2,513.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
1455 TULLIE RD NE
ATLANTA,GA 30329-2312

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,082.00	ADJUSTMENTS	2,562.25
COVERED CHARGES	67,681.00	CONTRACTUAL ALLOW	33,704.13
NON-COVERD CHARGES	1,401.00	TOTAL MEDICAID LIAB	33,976.87
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,976.87

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	19	0	10,089.00	270.00
ROUTINE NURSERY	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	19	0	10,089.00	270.00
SPECIAL CARE SERVICES				
CCU	3	0	1,980.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,980.00	0.00
TOTAL ACCOMODATIONS	22	0	12,069.00	270.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,864.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,793.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,298.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	768.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	96.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,999.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	380.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,035.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,293.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,456.00	0.00			

TOTAL ANCILLARY	55,612.00	1,131.00
TOTAL ACCOMODATIONS	12,069.00	270.00
TOTAL CHARGES	67,681.00	1,401.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	542,116.69	ADJUSTMENTS	18,730.37
COVERED CHARGES	488,148.94	CONTRACTUAL ALLOW	271,472.84
NON-COVERD CHARGES	53,967.75	TOTAL MEDICAID LIAB	216,676.10
		LESS: COB	159.73
		LESS: COPAYMENT	592.86
		REIMBURSEMENT	215,923.51
		ALL OTHER	200,037.12
		FEE SCHEDULE-LAB	15,232.10
		INJECTABLE DRUGS	654.29

TOTAL NUMBER OF CLAIMS 642

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,502.44	802.00	OTHER LAB	5,046.00	0.00
MED/SURG SUPPLY	18,641.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,021.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,511.00	8,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,879.00	0.00	FEE SCHEDULE LAB	126,642.00	19,989.35
EKG/ECG	5,888.00	0.00	MRI SERVICES	11,100.00	0.00
IV THERAPY	0.00	11.76	PROFESSIONAL FEES	0.00	1,056.00
OPERATING ROOM	1,587.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,213.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,240.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,628.50	3,872.64	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,507.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,509.00	12,452.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	68.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,210.00	2,875.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	10,365.00	246.00	NO CC/INVALID REV CODE	0.00	148.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	8,426.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	918.00	283.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,143.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,080.00	0.00			

TOTAL ANCILLARY	488,148.94	53,967.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	488,148.94	53,967.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2211110009253	03/02/11 - 03/02/11	04/25/11	0.00	61.00	0.00	0.00	0.00
31	2211111020379	03/30/11 - 03/30/11	04/25/11	0.00	87.00	0.00	0.00	0.00
TOTAL				0.00	148.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,381.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,323.25	CONTRACTUAL ALLOW	948.43
NON-COVERD CHARGES	58.00	TOTAL MEDICAID LIAB	1,374.82
		LESS: COB	1,363.00
		LESS: COPAYMENT	11.82
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	149.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	591.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	328.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,180.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	58.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,323.25	58.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,323.25	58.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,439.64	ADJUSTMENTS	50.00
COVERED CHARGES	18,196.64	CONTRACTUAL ALLOW	15,346.64
NON-COVERD CHARGES	243.00	TOTAL MEDICAID LIAB	2,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,757.00

TOTAL NUMBER OF CLAIMS 57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,577.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	192.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	819.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,305.00	17.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	48.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,030.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	145.00	178.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	18,196.64	243.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,196.64	243.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,247.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,040.00	CONTRACTUAL ALLOW	11,739.76
NON-COVERD CHARGES	207.00	TOTAL MEDICAID LIAB	4,300.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,300.24

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,472.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	628.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	476.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	234.00	207.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,388.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,040.00	207.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,040.00	207.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
PO BOX 860
MADISON,GA 30650-0860

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,781,860.38	ADJUSTMENTS	791,107.98
COVERED CHARGES	13,587,100.38	CONTRACTUAL ALLOW	9,471,854.80
NON-COVERD CHARGES	194,760.00	TOTAL MEDICAID LIAB	4,115,245.58
		LESS: COB	39,215.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,076,029.74

TOTAL NUMBER OF ADMISSIONS 499

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,920	0	1,564,800.00	96,195.00
ROUTINE NURSERY	368	0	327,188.00	24,463.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	5	0.00	0.00
TOTAL ROUTINE	2,288	5	1,891,988.00	120,658.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	192	0	475,983.00	0.00
NICU	12	0	24,600.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	204	0	500,583.00	0.00
TOTAL ACCOMODATIONS	2,492	5	2,392,571.00	120,658.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,657,331.10	0.00
MED/SURG SUPPLY	779,529.64	2,010.00
LABORATORY-GENERAL	1,654,154.00	1,982.00
RADIOLOGY-DIAGNOSTIC	368,001.00	0.00
CT SCAN	831,113.00	16,933.00
PHYSICAL THERAPY	120,831.00	0.00
EKG/ECG	122,084.00	0.00
IV THERAPY	465.00	0.00
OPERATING ROOM	1,051,942.00	0.00
LABOR/DELIVERY ROOM	169,082.00	0.00
RESPIRATORY SERVICES	564,223.00	130.00
ANESTHESIA	192,533.00	0.00
GI SERVICES	192,927.00	0.00
EMERGENCY ROOM	558,320.00	3,503.00
RECOVERY ROOM	237,703.00	0.00
LABORATORY PATHOLOGIC	89,764.00	0.00
RADIOLOGY THERAPEUTIC	20,225.00	0.00
OCCUPATIONAL THERAPY	49,534.00	0.00
SPEECH PATHOLOGY	19,450.00	0.00
RENAL DIALYSIS	100,941.00	28,898.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	929.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	172,987.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	245,583.00	1,008.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	107,962.00	17,778.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	552,643.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,444.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,572.52	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	78,022.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,759.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	141,659.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	84,745.12	715.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	216.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,194,529.38	74,102.00
TOTAL ACCOMODATIONS	2,392,571.00	120,658.00
TOTAL CHARGES	13,587,100.38	194,760.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	486,698.70	ADJUSTMENTS	0.00
COVERED CHARGES	473,116.70	CONTRACTUAL ALLOW	259,941.80
NON-COVERD CHARGES	13,582.00	TOTAL MEDICAID LIAB	213,174.90
		LESS: COB	213,174.90
		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	69	0	56,235.00	3,700.00
ROUTINE NURSERY	53	0	47,344.00	9,882.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	122	0	103,579.00	13,582.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	6	0	12,300.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6	0	12,300.00	0.00
TOTAL ACCOMODATIONS	128	0	115,879.00	13,582.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
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ATLANTA,GA 30368-2111

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	136,176.20	0.00
MED/SURG SUPPLY	9,155.50	0.00
LABORATORY-GENERAL	73,046.00	0.00
RADIOLOGY-DIAGNOSTIC	11,858.00	0.00
CT SCAN	22,250.00	0.00
PHYSICAL THERAPY	4,243.00	0.00
EKG/ECG	1,097.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	12,498.00	0.00
LABOR/DELIVERY ROOM	25,237.00	0.00
RESPIRATORY SERVICES	11,826.00	0.00
ANESTHESIA	4,625.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,234.00	0.00
RECOVERY ROOM	11,932.00	0.00
LABORATORY PATHOLOGIC	1,190.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,996.00	0.00
SPEECH PATHOLOGY	1,143.00	0.00
RENAL DIALYSIS	6,543.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,667.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,797.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,822.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,729.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,365.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,133.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	675.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	357,237.70	0.00
TOTAL ACCOMODATIONS	115,879.00	13,582.00
TOTAL CHARGES	473,116.70	13,582.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,254,898.68	ADJUSTMENTS	332,397.19
COVERED CHARGES	8,063,259.54	CONTRACTUAL ALLOW	6,396,005.27
NON-COVERD CHARGES	1,191,639.14	TOTAL MEDICAID LIAB	1,667,254.27
		LESS: COB	25,274.94
		LESS: COPAYMENT	3,253.34
		REIMBURSEMENT	1,638,725.99
		ALL OTHER	1,449,543.96
		FEE SCHEDULE-LAB	111,937.68
		INJECTABLE DRUGS	77,244.35

TOTAL NUMBER OF CLAIMS 3,519

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
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SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	335,286.65	17,949.10
MED/SURG SUPPLY	365,735.72	9,950.00
LABORATORY-GENERAL	0.00	624.00
RADIOLOGY-DIAGNOSTIC	548,248.00	15,258.00
CT SCAN	896,943.00	260,160.00
PHYSICAL THERAPY	3,852.00	3,712.00
EKG/ECG	141,701.00	545.00
IV THERAPY	27,879.00	0.00
OPERATING ROOM	538,834.86	237,584.14
LABOR/DELIVERY ROOM	67,422.00	475.00
RESPIRATORY SERVICES	42,103.00	3,482.00
ANESTHESIA	98,702.00	23,839.00
GI SERVICES	249,188.00	44,937.00
EMERGENCY ROOM	1,512,157.00	86,090.00
RECOVERY ROOM	181,048.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	131,434.00	776.00
OCCUPATIONAL THERAPY	730.00	1,559.00
SPEECH PATHOLOGY	680.00	355.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	1,023.00	0.00
CLINIC SERVICES	67,499.00	4,266.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	322,319.00	100,730.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	58,898.00	15,856.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	174,662.00	22,250.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	218,523.00	57,457.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	178,656.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	210,830.24	39,719.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	57,261.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,785.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,136,825.00	173,219.00
MRI SERVICES	123,044.00	6,143.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	87.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	368,903.07	64,517.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	108.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	78.00

TOTAL ANCILLARY	8,063,259.54	1,191,639.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,063,259.54	1,191,639.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
626	2211066005682	11/23/10 - 11/23/10	03/14/11	0.00	78.00	0.00	0.00	0.00
TOTAL				0.00	78.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

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SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	216,955.20	ADJUSTMENTS	0.00
COVERED CHARGES	158,051.80	CONTRACTUAL ALLOW	72,710.91
NON-COVERD CHARGES	58,903.40	TOTAL MEDICAID LIAB	85,340.89
		LESS: COB	85,309.08
		LESS: COPAYMENT	31.81
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

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SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,132.35	125.00
MED/SURG SUPPLY	6,218.00	0.00
LABORATORY-GENERAL	0.00	79.00
RADIOLOGY-DIAGNOSTIC	12,110.00	0.00
CT SCAN	5,860.00	26,081.00
PHYSICAL THERAPY	1,610.00	322.00
EKG/ECG	1,904.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,246.00	9,508.00
LABOR/DELIVERY ROOM	7,677.00	2,900.00
RESPIRATORY SERVICES	1,048.00	0.00
ANESTHESIA	1,752.00	542.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,856.00	3,376.00
RECOVERY ROOM	4,120.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	629.00	0.00
CLINIC SERVICES	316.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,368.00	6,883.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,689.00	54.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,824.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,180.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,652.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,364.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	181.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,518.00	4,170.00
MRI SERVICES	6,109.00	2,755.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	688.20	2,108.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	158,051.80	58,903.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	158,051.80	58,903.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	333,231.85	ADJUSTMENTS	5,347.11
COVERED CHARGES	306,716.45	CONTRACTUAL ALLOW	287,417.15
NON-COVERD CHARGES	26,515.40	TOTAL MEDICAID LIAB	19,299.30
		LESS: COB	0.00
		LESS: COPAYMENT	489.02
		REIMBURSEMENT	18,810.28

TOTAL NUMBER OF CLAIMS 345

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,927.75	0.00
MED/SURG SUPPLY	606.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,135.00	477.00
CT SCAN	18,888.00	7,167.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,333.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	4,420.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	149,615.00	3,182.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,922.00	6,015.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,158.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,071.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	242.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,075.00	8,680.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,323.00	994.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	306,716.45	26,515.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	306,716.45	26,515.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,719.75	ADJUSTMENTS	0.00
COVERED CHARGES	19,758.75	CONTRACTUAL ALLOW	13,560.53
NON-COVERD CHARGES	961.00	TOTAL MEDICAID LIAB	6,198.22
		LESS: COB	6,189.22
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	647.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	726.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	90.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,953.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,056.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,038.00	242.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,043.00	629.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,758.75	961.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,758.75	961.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,742,060.06	ADJUSTMENTS	36,902.66
COVERED CHARGES	1,622,386.36	CONTRACTUAL ALLOW	1,358,822.65
NON-COVERD CHARGES	119,673.70	TOTAL MEDICAID LIAB	263,563.71
		LESS: COB	0.00
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	263,011.71

TOTAL NUMBER OF CLAIMS 50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,135.25	2,615.90
MED/SURG SUPPLY	124,503.65	24,786.00
LABORATORY-GENERAL	0.00	1,680.00
RADIOLOGY-DIAGNOSTIC	12,482.00	3,712.00
CT SCAN	62,324.00	1,338.00
PHYSICAL THERAPY	2,646.00	1,638.00
EKG/ECG	3,277.00	0.00
IV THERAPY	18,961.00	0.00
OPERATING ROOM	231,894.00	12,661.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,082.00	0.00
ANESTHESIA	17,551.00	10,298.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,160.00	992.00
RECOVERY ROOM	24,884.00	0.00
LABORATORY PATHOLOGIC	0.00	349.00
RADIOLOGY THERAPEUTIC	351,248.00	4,770.00
OCCUPATIONAL THERAPY	483.00	7,545.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,210.00	189.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,231.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,198.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,831.00	280.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	49,063.00	11,710.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,771.82	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,844.60	3,341.40
MRI SERVICES	0.00	2,794.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	618,606.04	25,474.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,622,386.36	116,173.70
TOTAL ACCOMODATIONS	0.00	3,500.00
TOTAL CHARGES	1,622,386.36	119,673.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,912.36	ADJUSTMENTS	0.00
COVERED CHARGES	31,202.86	CONTRACTUAL ALLOW	17,684.01
NON-COVERD CHARGES	17,709.50	TOTAL MEDICAID LIAB	13,518.85
		LESS: COB	13,512.85
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
PO BOX 102111
ATLANTA,GA 30368-2111

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/10 THROUGH 06/30/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,542.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,873.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,572.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	242.00	23.00
EKG/ECG	276.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,723.50	12,943.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	876.00	4,607.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27.00	136.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,200.96	0.00			

TOTAL ANCILLARY	31,202.86	17,709.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,202.86	17,709.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/11	THROUGH	12/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL
PO BOX 504692
SAINT LOUIS,MO 63150-4692

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	408,954.72	ADJUSTMENTS	9,921.70
COVERED CHARGES	352,569.81	CONTRACTUAL ALLOW	303,718.28
NON-COVERD CHARGES	56,384.91	TOTAL MEDICAID LIAB	48,851.53
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	48,851.53

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	49	42	40,915.00	51,814.00
ROUTINE NURSERY	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	49	42	40,915.00	51,814.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	49	42	40,915.00	51,814.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,674.25	0.00	OTHER LAB	2,966.25	0.00
MED/SURG SUPPLY	43,634.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,691.89	0.00	EDUCATION & TRAINING	626.00	0.00
RADIOLOGY-DIAGNOSTIC	2,853.99	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,404.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,503.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,785.05	0.00	MRI SERVICES	2,227.31	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	639.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118,570.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	441.54	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,821.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,521.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	1,204.09	0.00			
BLOOD	1,170.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	808.50	166.16			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	517.65	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	311,654.81	4,570.91
TOTAL ACCOMODATIONS	40,915.00	51,814.00
TOTAL CHARGES	352,569.81	56,384.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/11	THROUGH	12/31/11
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AMERICAN TRANSITIONAL HOSPITAL INC.
PO BOX 642369
PITTSBURGH,PA 15264-2369

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,914,386.34	ADJUSTMENTS	167,496.78
COVERED CHARGES	4,826,198.68	CONTRACTUAL ALLOW	2,896,339.08
NON-COVERD CHARGES	88,187.66	TOTAL MEDICAID LIAB	1,929,859.60
		LESS: COB	58,646.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,871,212.78

TOTAL NUMBER OF ADMISSIONS 281

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	748	0	807,266.00	32,628.00
ROUTINE NURSERY	254	0	353,516.00	8,588.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,002	0	1,160,782.00	41,216.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	154	0	596,210.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	154	0	596,210.00	0.00
TOTAL ACCOMODATIONS	1,156	0	1,756,992.00	41,216.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	362,698.62	8,173.75
MED/SURG SUPPLY	374,259.04	1,284.00
LABORATORY-GENERAL	224,631.00	0.00
RADIOLOGY-DIAGNOSTIC	164,308.00	0.00
CT SCAN	99,268.00	847.00
PHYSICAL THERAPY	34,675.50	0.00
EKG/ECG	9,498.00	0.00
IV THERAPY	57,359.00	928.00
OPERATING ROOM	594,847.50	0.00
LABOR/DELIVERY ROOM	155,402.50	0.00
RESPIRATORY SERVICES	75,899.50	74.50
ANESTHESIA	53,254.50	0.00
GI SERVICES	26,963.00	0.00
EMERGENCY ROOM	140,716.00	0.00
RECOVERY ROOM	80,833.00	0.00
LABORATORY PATHOLOGIC	17,226.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	14,921.00	0.00
SPEECH PATHOLOGY	9,322.00	0.00
RENAL DIALYSIS	5,264.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	247.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,045.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	55,815.50	6,715.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,748.00	4,660.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	114,516.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,018.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,877.05	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,444.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	19,671.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	49,146.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	288,002.47	4,617.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,069,206.68	46,971.66
TOTAL ACCOMODATIONS	1,756,992.00	41,216.00
TOTAL CHARGES	4,826,198.68	88,187.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,863.07	ADJUSTMENTS	0.00
COVERED CHARGES	26,335.57	CONTRACTUAL ALLOW	19,896.84
NON-COVERD CHARGES	527.50	TOTAL MEDICAID LIAB	6,438.73
		LESS: COB	6,438.73
		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	9	0	9,450.00	522.00
ROUTINE NURSERY	2	0	1,414.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	10,864.00	522.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	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
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	10,864.00	522.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,535.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	442.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	527.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,468.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	521.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	132.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	503.76	5.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,471.57	5.50
TOTAL ACCOMODATIONS	10,864.00	522.00
TOTAL CHARGES	26,335.57	527.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,591,129.49	ADJUSTMENTS	8,633.45
COVERED CHARGES	1,328,710.41	CONTRACTUAL ALLOW	955,930.72
NON-COVERD CHARGES	262,419.08	TOTAL MEDICAID LIAB	372,779.69
		LESS: COB	3,877.15
		LESS: COPAYMENT	1,099.73
		REIMBURSEMENT	367,802.81
		ALL OTHER	338,942.20
		FEE SCHEDULE-LAB	23,027.95
		INJECTABLE DRUGS	5,832.66

TOTAL NUMBER OF CLAIMS 723

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,116.50	704.00
MED/SURG SUPPLY	75,325.50	6,097.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,142.00	2,075.00
CT SCAN	111,034.50	42,100.50
PHYSICAL THERAPY	5,441.00	1,492.50
EKG/ECG	6,766.50	87.00
IV THERAPY	73,389.00	895.50
OPERATING ROOM	200,945.50	92,923.00
LABOR/DELIVERY ROOM	3,048.00	304.50
RESPIRATORY SERVICES	2,022.50	0.00
ANESTHESIA	23,935.50	0.00
GI SERVICES	3,806.50	12,528.50
EMERGENCY ROOM	250,094.00	1,672.50
RECOVERY ROOM	45,846.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	7,834.00
OCCUPATIONAL THERAPY	0.00	1,204.00
SPEECH PATHOLOGY	0.00	1,638.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,562.00	148.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,072.00	908.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,440.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,702.50	24,968.18
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,807.50	29,702.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,279.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	62,518.80	217.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	15,769.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	240.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	99,043.00	18,091.50
MRI SERVICES	32,768.00	3,712.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,835.11	12,875.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,328,710.41	262,419.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,328,710.41	262,419.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,136.15	ADJUSTMENTS	0.00
COVERED CHARGES	47,182.49	CONTRACTUAL ALLOW	11,583.92
NON-COVERD CHARGES	16,953.66	TOTAL MEDICAID LIAB	35,598.57
		LESS: COB	35,571.57
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,141.25	0.00
MED/SURG SUPPLY	1,008.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,118.00	0.00
CT SCAN	2,288.00	5,714.00
PHYSICAL THERAPY	0.00	353.00
EKG/ECG	0.00	0.00
IV THERAPY	4,435.00	0.00
OPERATING ROOM	5,466.00	0.00
LABOR/DELIVERY ROOM	0.00	320.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	645.00	0.00
GI SERVICES	3,499.00	1,837.00
EMERGENCY ROOM	9,544.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	236.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,098.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,141.00	7,496.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,309.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	555.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	911.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,045.50	77.00
MRI SERVICES	7,856.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32.74	8.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	47,182.49	16,953.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,182.49	16,953.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,923.66	ADJUSTMENTS	55.94
COVERED CHARGES	34,504.66	CONTRACTUAL ALLOW	32,378.94
NON-COVERD CHARGES	3,419.00	TOTAL MEDICAID LIAB	2,125.72
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	2,089.72

TOTAL NUMBER OF CLAIMS 38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	382.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	326.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	783.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,353.00	3,419.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,753.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,716.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	2,826.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189.00	0.00			

TOTAL ANCILLARY	34,504.66	3,419.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,504.66	3,419.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,976.87	ADJUSTMENTS	0.00
COVERED CHARGES	3,615.39	CONTRACTUAL ALLOW	1,580.99
NON-COVERD CHARGES	361.48	TOTAL MEDICAID LIAB	2,034.40
		LESS: COB	2,028.40
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	318.00	0.00	OTHER THERAPEUTIC SVC	0.00	108.50
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	831.00	228.50
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,289.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30.86	24.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	920.00	0.00			

TOTAL ANCILLARY	3,615.39	361.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,615.39	361.48

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,348.75	ADJUSTMENTS	0.00
COVERED CHARGES	148,879.75	CONTRACTUAL ALLOW	123,063.45
NON-COVERD CHARGES	13,469.00	TOTAL MEDICAID LIAB	25,816.30
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	25,789.30

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,510.08	0.00
MED/SURG SUPPLY	16,521.00	2,169.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,875.00	0.00
CT SCAN	2,017.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	517.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	10,268.00	7,686.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,708.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,717.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	356.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	2,850.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	67,546.00	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/OBSERV. RM	2,131.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,096.50	408.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,972.47	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	148,879.75	13,469.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,879.75	13,469.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/11 THROUGH 12/31/11
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **